CCME

2018 External Quality Review

MOLINA HEALTHCARE OF SOUTH CAROLINA

Submitted: May 11, 2018

Prepared on behalf of the
South Carolina Department
of Health and Human Service

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. The review determines the level of performance demonstrated by Molina Healthcare of South Carolina (Molina) since the 2017 Annual Review. This report contains a description of the process and the results of the *2018 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review are to:

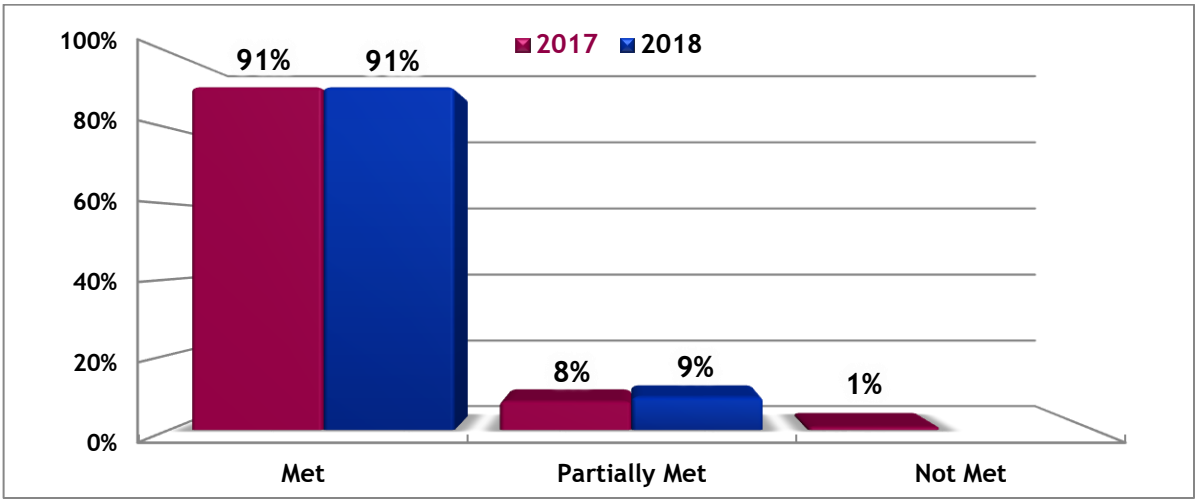
- Determine if Molina is in compliance with service delivery as mandated in the MCO contract with SCDHHS during the reporting period.
- Evaluate the status of deficiencies identified during the 2017 Annual Review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback about potential areas for improvement.
- Assure that contracted health care services are being delivered and are of good quality.

The process used for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of performance improvement projects (PIPs), validation of performance improvement measures, and validation of satisfaction surveys.

Overall Findings

The 2018 Annual EQR review shows that Molina has achieved a "Met" score for 91% of the standards reviewed and 9% of the standards are scored as "Partially Met." *Figure 1: Annual EQR Comparative Results* provides a comparison of Molina's current review results with the 2017 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items, and detailed recommendations can be found in the narrative of this report.

Administration:

Dora Wilson is the Interim Plan President for Molina. She is responsible for the day-to-day business activities and onsite discussion revealed that Molina is actively working to fill the Plan President position vacancy. Dr. Cheryl Shafer (Internal Medicine) is the Chief Medical Officer and Vice President of Medical Affairs. Molina currently has two additional Medical Directors and an open position for a Medical Director due to the recent departure of Dr. Shrouds.

The Associate Vice President of Quality Improvement is Patricia Zigon and she is responsible for the Quality Improvement activities in several states. Molina indicated that Wilson Huang, Manager of Quality Interventions, fulfills the *SCDHHS MCO Contract* requirement for a full-time Quality Improvement Manager/Director located in South Carolina. Mr. Huang's background is in biological engineering and engineering management, and he does not hold any quality certifications as suggested by the *SCDHHS MCO Contract, Section 2.2*.

In reference to the Information System Capabilities Assessment (ISCA) review, Molina has a well-documented system and meets claims processing timeframe requirements. Molina's systems provide all required data collection and processing, and address data and system security.

Provider Services:

The Peer Review & Credentialing Committee (PRC) is chaired by Dr. Delores Baker, Medical Director, with the Chief Medical Officer, Cheryl Shafer, serving as back-up Committee Chair. Additional voting members include Medical Director, Dr. Nickitas Thomarios, and five network providers with the specialties of OB/GYN, internal medicine, pediatrics, cardiology, and psychiatry. Meeting minutes showed active committee member participation and a quorum was met per all meeting minutes CCME reviewed.

Molina has a comprehensive credentialing program; however, CCME identified several issues including the Termination for Cause List is not mentioned as a query responsibility and the credentialing/recredentialing files lacked evidence that the Termination for Cause List was queried. Molina also does not pursue hospital admitting arrangements for behavioral health providers that are not MDs.

A few issues were identified with the preventive and clinical practice guidelines, such as web-links requiring a membership to access the information, retired guidelines, and inconsistencies between documents and the website on the guidelines that have been adopted.

CCME conducted a Telephonic Provider Access Study focused on primary care providers. Results show calls were successfully answered 49% of the time (115 out of 237) when omitting 50 calls answered by personal or general voicemail messaging services. When compared to last year's results of 44%, this year had an increase in successful calls, but the increase is not statistically significant.

Member Services:

Molina's Member Handbook is written in an appropriate format and reading level for members and contains most required information; however, CCME noted instances of incorrect or missing information. Member Services Call Center functions are conducted by staff in Texas, Michigan, and California, and Molina communicates updates to member benefits, services, policies, etc. to Call Center staff. A searchable database allows Call Center staff to quickly and easily retrieve information specific to caller needs.

As confirmed during the onsite visit, Molina has not developed written policies, procedures, or a program description defining EPSDT processes and requirements as required by the *SCDHHS Contract*. Molina provided evidence that it is conducting appropriate monitoring and tracking of EPSDT-eligible members.

Response rates for the Adult and Child Consumer Assessment of Healthcare Providers and Systems® (CAHPS) surveys fell below NCQA's target of 40%, and CCME offered recommendations to increase the response rates for future surveys.

CCME noted minor issues in the documentation of grievance processes and requirements in grievance policies/procedures as well as the Member Handbook and Provider Manual. Grievance files reflect timely acknowledgement and resolution as well as review by appropriate staff; however, several files for grievances which were referred to other internal departments for investigation and resolution did not contain documentation of the findings or actions taken by the departments to resolve the grievance.

Quality Improvement:

Molina provided the 2017 Medicaid Quality Improvement Program Description as evidence the program is designed to provide the structure and key processes for ongoing improvements of care and services Molina provides. The program description was reviewed and approved by the Quality Improvement Committee (QIC) and Molina's Board of Directors.

Molina uses Inovalon, a certified software organization, to calculate HEDIS rates. The comparison of the previous and current years revealed a strong increase in Asthma Medication Ratio and Metabolic Monitoring for Children and Adolescents on Antipsychotics. The measures that decreased are the Statin Therapy for Patients With Cardiovascular Disease and Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia.

The Plan submitted four Performance Improvement Projects (PIPs) for validation. One was retired and two of the three active projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. They included Well Care (Clinical) and Improving Claims Accuracy and Provider Satisfaction. The Well Care (Clinical) PIP scored within the "High Confidence" range and the Provider Satisfaction PIP scored within the "Confidence" range. The baseline goals, benchmarks, and interventions contain errors.

Although it was not validated this year, CCME conducted a preliminary review of the Breast Cancer Screening PIP. The longevity of this PIP is still showing very little positive effect on the breast cancer screening rate. The rates have increased, but the actual effect from the mobile mammogram appears to be minimal, as reflected in the graph on the last page of the report that shows most counties have less than 5% of members that are compliant because of the mobile mammogram.

For the Interventions Table, the barriers are listed on the right, and the interventions to address the barriers should be in the left column. The first part of the Table displays this information correctly, but the latter part of the Table shows barriers and does not explain how the interventions address those barriers. For example, on page 84 the barrier is Provider Engagement, and the intervention is listed as "Hope Health- 29 eligible members that have not received a mammography." This is not actually an intervention to

address Provider Engagement. CCME also identified a barrier that says "Members Are Unable to Attend Mobile Mammogram Events due to Child Care Needs, Difficulty Taking Time from their Job or Additional Personal Constraints," and the intervention is a gift card. It is not readily apparent that a gift card will help with child care needs and difficulty with taking time from a job for health care.

Utilization Management:

Molina's Healthcare Services (HCS) Medicaid Program Description outlines and describes the Utilization Management (UM) Program. UM policies and procedures define how utilization management, medical necessity determinations, appeals and case management services are operationalized to provide services to members. The Chief Medical Officer (CMO), Cheryl Shafer, MD, provides oversight of UM activities.

CCME found that the methodology for inter-rater reliability (IRR) testing is not consistent for all reviewers issuing UM determinations, and a quality improvement plan is provided to address it. Documentation issues related to pharmacy were identified in policies, procedures, the Member Handbook, and the Provider Manual and recommendations are included to address deficiencies.

Delegation:

Molina executes written agreements with all entities performing delegated services. Molina has a detailed process of oversight for delegated entities and provided proof of oversight to CCME. A few issues such as inconsistency in scoring between the entities and improper scoring in the oversight tools are discussed in detail in the respective report section.

State Mandated Services:

Provider compliance with the provision of EPSDT services and immunizations is assessed via the annual medical record review process conducted by the Quality Improvement Department.

Molina provides all core benefits required by the *SCDHHS Contract*.

All deficiencies noted during the previous EQR were corrected.

Table 1, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2017 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2017	30	2	1	0	0	33
2018	39	0	0	0	0	39
Provider Services						
2017	69	5	1	0	0	75
2018	67	11	0	0	0	78
Member Services						
2017	35	2	0	0	0	37
2018	29	4	0	0	0	33
Quality Improvement						
2017	13	2	0	0	0	15
2018	14	1	0	0	0	15
Utilization						
2017	33	5	0	0	0	38
2018	42	3	0	0	0	45
Delegation						
2017	2	0	0	0	0	2
2018	1	1	0	0	0	2
State Mandated Services						
2017	3	0	1	0	0	4
2018	4	0	0	0	0	4

METHODOLOGY

The process used by CCME for the EQR is based on CMS developed protocols for Medicaid MCO/PIHP EQRs and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On February 5, 2018, CCME sent notification to Molina that the Annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for the desk review and an invitation for a teleconference to allow Molina to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Molina on February 19, 2018, and reviewed in the offices of CCME (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review is a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on April 12-13, 2018, at the Molina office located in Charleston, SC. The onsite visit focused on areas not covered in the desk review or items needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following table and are based on the regulations set forth in *Title 42 of the Code of Federal Regulations (CFR), Part 438*, and the contract requirements between Molina and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. We identify areas of review as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met") failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated" on the tabular spreadsheet (Attachment 4).

A. Administration

The Carolinas Center for Medical Excellence (CCME) conducted an Administration review of the health plan focused on policies and procedures, staffing, information systems, compliance, and confidentiality (Health Insurance Portability and Accountability Act (HIPAA) Privacy Practices).

Molina Healthcare of South Carolina (Molina) has the support of its Long Beach, California based parent company, Molina Healthcare, Inc. Dora Wilson is the Interim Plan President for Molina. She is responsible for the day-to-day business activities and reports to the local Board of Directors and the Molina Regional Vice President in Michigan. CCME confirmed during the onsite visit that Molina is actively recruiting to fill the Plan President position vacancy.

Dr. Cheryl Shafer (Internal Medicine) is the Chief Medical Officer and Vice President of Medical Affairs. Additional Medical Directors include Dr. Delores Baker (Ob-Gyn) and Dr. Nickitas Thomarios (Psychiatrist). Molina has an open position for a Medical Director due to the recent departure of Dr. Shrouds. All Medical Directors are licensed in South Carolina.

The Associate Vice President of Quality Improvement is Patricia Zigon. Ms. Zigon is responsible for the Quality Improvement activities in several states. Molina indicated that Wilson Huang, Manager of Quality Interventions, fulfills the *SCDHHS MCO Contract* requirement for a full-time Quality Improvement Manager/Director located in South Carolina. Mr. Huang does not hold any quality certifications as suggested by the *SCDHHS MCO Contract, Section 2.2*. His background is in biological engineering and engineering management. Molina may want to consider requiring relevant experience in healthcare quality improvement or a certification in quality for the Quality Manager role.

The Pharmacy Director is Alfred Romay, PharmD. He is not licensed in South Carolina but indicated that he holds licenses in multiple states during the onsite visit.

The Information Systems Capabilities Assessment (ISCA) showed that Molina has a well-documented system and meets claims processing timeframes. Documentation demonstrates Molina can provide required reports and meet contractual obligations. Molina's systems provide all required data collection and processing, including data and system security. Molina has a Disaster Recovery/Business Continuity Plan and provided evidence of successful testing.

Multiple documents such as policies and procedures, the South Carolina Compliance Plan, and a Fraud, Waste and Abuse Plan address Molina's compliance to program integrity requirements.

Figure 2, Administration Findings indicates Molina received a "Met" score for all Administration standards. *Table 2, Administration Comparative Data* highlights standards reflecting a change in score between 2017 and 2018.

Figure 2: Administration Findings

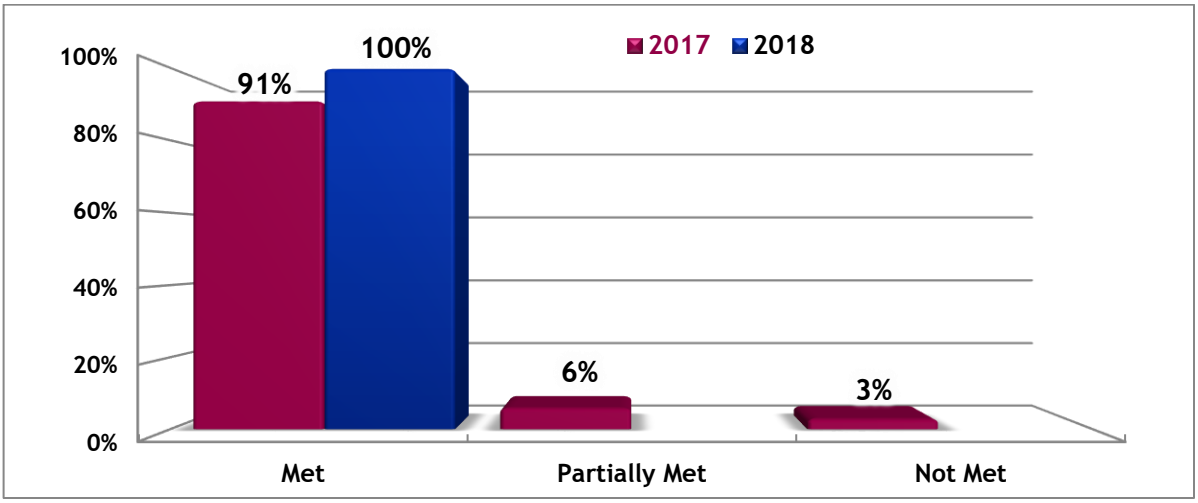


Table 2: Administration Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Management Information Systems	The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract	Not Met	Met
	The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Partially Met	Met
Compliance/ Program Integrity	The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Molina's ISCA review revealed complete Information Technology (IT) systems documentation; employee training, auditing and mentoring; and a focus on system and physical access security.

Weaknesses

- The Pharmacy Director is Alfred Romay, PharmD. He is not licensed in South Carolina but indicated that he holds licensure in multiple states.
- Molina indicated that Wilson Huang, Manager of Quality Interventions, fulfills the *SCDHHS MCO Contract* requirement for a full-time Quality Improvement Manager/Director located in South Carolina. Mr. Huang does not hold any quality certifications as suggested by the *SCDHHS MCO Contract, Section 2.2*. His background is in biological engineering and engineering management.
- Compliance Committee Minutes reflect member participation; however, it is difficult to determine who are voting members of the committee.

Recommendations

- The Pharmacy Director should consider obtaining a South Carolina license.
- The Quality Manger should consider obtaining a quality certification.
- Update Compliance Committee Minutes to define the voting members of the Compliance Committee and when they are in attendance or absent.

B. Provider Services

CCME conducted a review of all Provider Services policies, procedures, the provider agreement, provider training and educational materials, provider network information, credentialing/recredentialing files, and practice guidelines.

The Peer Review & Credentialing Committee (PRC) provides oversight for the Provider Credentialing Program and peer review for certain quality of care concerns. Dr. Delores Baker, Medical Director, chairs the Committee with the Chief Medical Officer, Cheryl Shafer serving as back-up Committee Chair. Additional voting members include Medical Director, Dr. Nickitas Thomarios, and five network providers. Voting committee members represent the specialties of OB/GYN, internal medicine, pediatrics, cardiology, and psychiatry. A quorum is met with the presence of three network physician members. Meeting minutes showed active participation by committee members and all meeting minutes CCME reviewed reflected that a quorum was met for all decisions.

Molina has a comprehensive credentialing program; however, the Termination for Cause List is not mentioned as a query responsibility and the credentialing/recredentialing files lacked evidence that the Termination for Cause List was queried. Molina indicated during onsite discussion that the Termination for Cause list is included in its query processes. In addition, it was noted that Molina does not pursue hospital admitting arrangements for

behavioral health providers who are not MDs, but hospital admitting arrangements should be addressed for all providers during the credentialing/recredentialing process.

A review of preventive and clinical practice guidelines revealed some guidelines required a membership to access the documents via web-links, a few of the web-links indicated the guidelines were retired, and inconsistencies exist for clinical practice guidelines between what is listed on the website verses what Molina indicated in documents they have adopted.

Provider Access and Availability Study

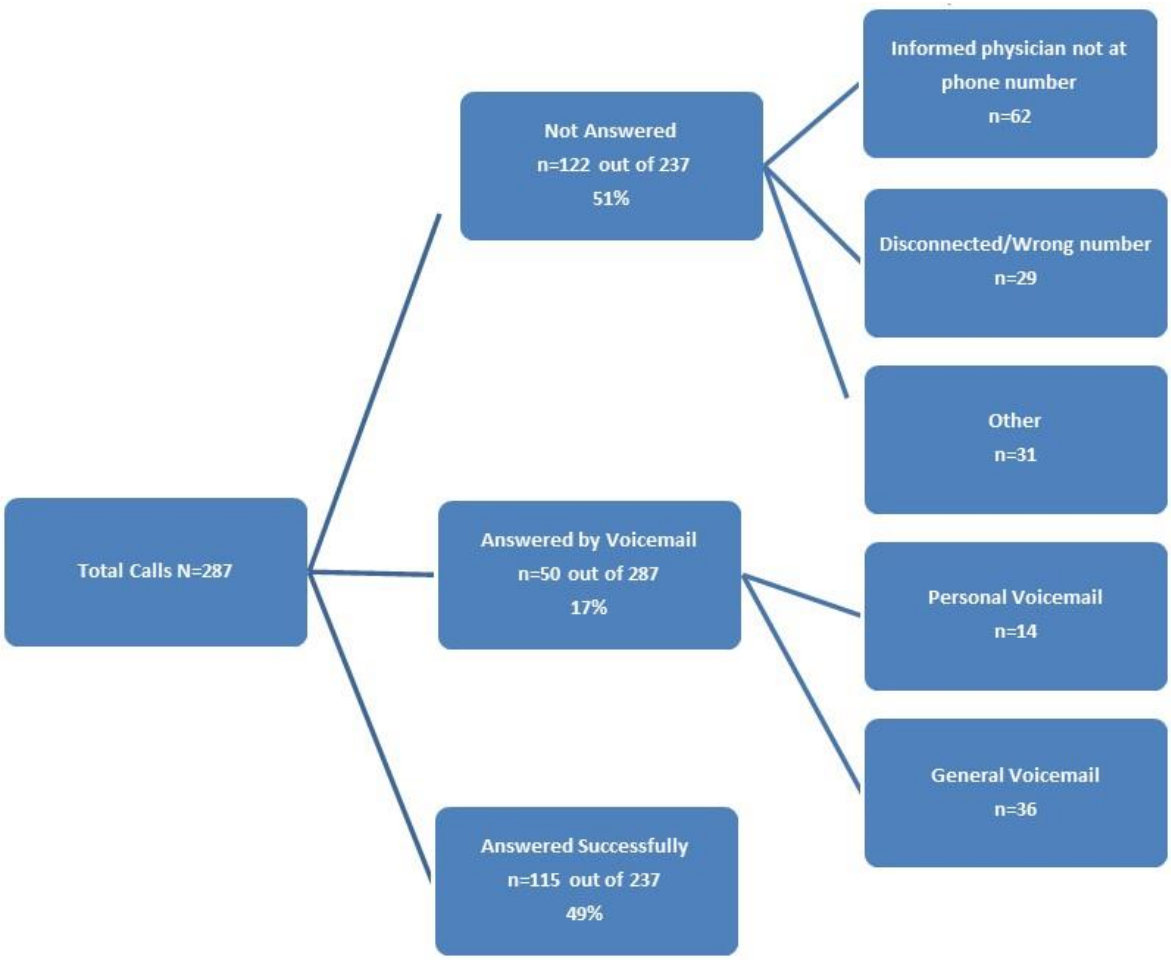
As part of the annual EQR process for Molina, CCME conducted a Telephonic Provider Access Study focused on primary care providers (PCPs). The Molina Provider File contained a population of 2,745 PCPs. From that population, CCME selected a random sample of 287 PCPs for the provider access study. PCPs were chosen based on the following criteria: MD, DO, NP, ANP, CFNP, and FNP. The specialties selected were Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Pediatrics. Only Providers located in SC and documented as accepting new patients were selected for the sample. CCME attempted to contact the sampling of providers and ask a series of questions regarding the access members have with the contracted providers.

Table 3: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact p-value
2017 Review	305	44%	.24
2018 Review	287	49%	

The results of the Telephonic Provider Access Study conducted by CCME demonstrated calls were successfully answered 49% (115 out of 237) of the time when omitting 50 calls answered by personal or general voicemail messaging services (see Figure 3).

Figure 3: Telephonic Provider Access Study Results



When compared to last year's results of 44%, this year had an increase in successful calls but the increase is not statistically significant (p=.24).

For calls not answered successfully (n=115 calls), 62 (54%) were unsuccessful because the provider was not at the office or phone number listed. Of the 111 who answered the question regarding accepting Molina, 87 (78%) of the providers indicated that they accept Molina, and four (4%) indicated that this occurred only under certain conditions. Sixty-seven out of 92 (73%) responded that they are accepting new Medicaid patients.

Regarding a screening process for new patients, 23 (34%) of the 68 providers that responded to the item indicated that an application or prescreen is necessary. Out of 22, two (9%) indicated that an application must be completed, whereas 11 (50%) require a review of medical records before accepting a new patient, and six (27%) require both. When the office was asked about the next available routine appointment, 48 out of 67 (72%) of the 100 responses met contract requirements.

Figure 4, Provider Services Findings, shows that 86% of the standards in Provider Services were scored as "Met." *Table 4, Provider Services Comparative Data*, highlights standards showing a change in score from 2017 to 2018.

Figure 4: Provider Services Findings

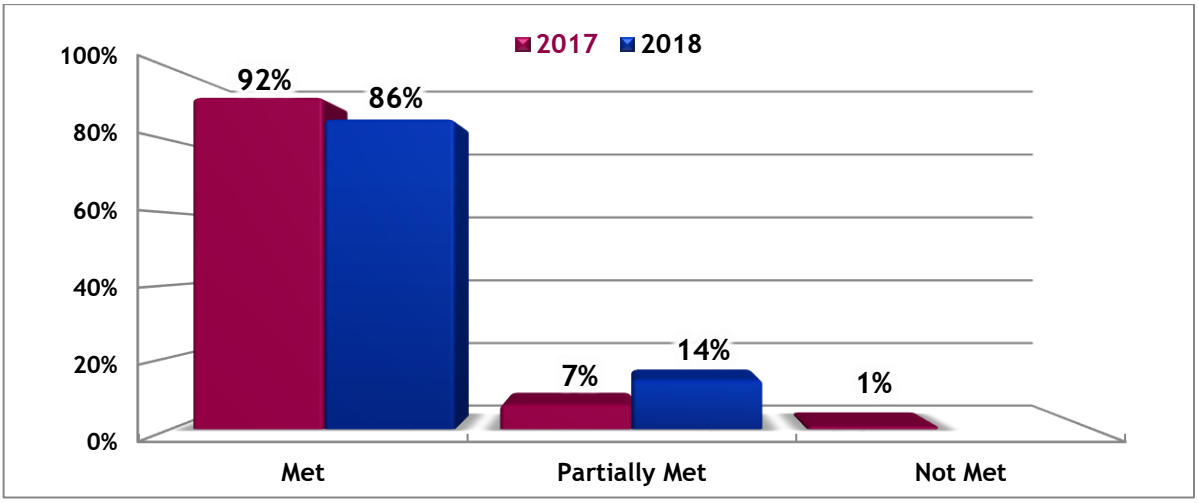


Table 4: Provider Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Credentialing and Recredentialing	Credentialing: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met	Partially Met
	In good standing at the hospital designated by the provider as the primary admitting facility	Met	Partially Met
	Recredentialing: Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met	Partially Met
	In good standing at the hospitals designated by the provider as the primary admitting facility	Met	Partially Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met	Partially Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Credentialing and Recredentialing	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Partially Met
Adequacy of the Provider Network	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Partially Met	Met
	Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Partially Met	Met
	The MCO maintains a provider directory that includes all requirements outlined in the contract	Met	Partially Met
	The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	Met
Provider Education	Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Partially Met	Met
Primary and Secondary Preventive Health Guidelines	The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	Partially Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Primary and Secondary Preventive Health Guidelines	The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The Provider Manual is detailed and contains sufficient information for providers to navigate the plan. Additional resources and information are available on the website such as provider toolkits, provider training for cultural competency and patient engagement, provider newsletters, etc.

Weaknesses

- The following were issues found in Policy MHSC CR-01, Credentialing Program Policy:
  - Page six states, "Another accepted source listed for the credential as defined in the attached Addendum A (Practitioner Criteria and Primary Source Verification Table);" however, Addendum A is not found in the document. CCME confirmed during the onsite discussion that the information found in Addendum A was placed in a table in the document beginning on page eight.
  - Page 35 also mentions the Practitioner Criteria and Primary Source Verification Table. CCME suggests adding the title to the table on page eight, "Practitioner Criteria and Primary Source Verification Table" or correcting the reference in the document.
- The 2017 QI Program Description states the name of the credentialing committee as the Professional Review Committee (PRC), however, the Credentialing Program Policy and committee charter refers to the committee as the Peer Review & Credentialing Committee (PRC).
- Proof of query of the Terminated for Cause List was not in the credentialing/ recredentialing files.
- Molina indicated during onsite discussion it does not pursue hospital admitting arrangements for behavioral health providers that are not MDs; however, admitting arrangements should be addressed for all providers.
- Policy MHSC CR-02, Assessment of Organizational Providers, does not address the need to query the Termination for Cause List and the file review did not reflect the list had been queried.

- Policy MHSC CR_01, Credentialing Program Policy, defines various screenings for ongoing monitoring but does not specify if the Termination for Cause List is queried.
- Policy MHSC CR-01, Credentialing Program Policy, contains the following information that is no longer applicable per onsite discussion, "At least once every quarter, the Corporate Credentialing Department pulls a query from the credentialing database and randomly selects a sample of practitioners. The credentialing employee looks up each on the MHSC web-based Practitioner Directory and validates that the data exactly matches the credentialing data in the credentialing database. A report is created in a spreadsheet format that indicates if all the data matched or if there were any discrepancies. If any discrepancies are discovered, the errors will immediately be corrected. If a trend of errors is identified in this process, a root cause analysis will be conducted to prevent similar errors from occurring in the future."
- The Accessibility of Services Report did not reflect actions taken to address non-compliant providers.
- Results of the Telephonic Provider Access Study conducted by CCME showed calls were successfully answered 49% of the time, but when compared to last year's results of 44%, the increase was not statistically significant.
- The following issues were identified in reviewing the preventive health guidelines:
  - When the Children and Adolescents link is clicked, it navigates the user to a page with additional links for Children up to 24 Months, Children 2-19 Years, and Child/Adolescent Immunization Schedules. The links for Children up to 24 Months and Children 2-19 Years are not accessible because membership is required to access the information.
  - Upon clicking the Adults guidelines link, the user is taken to a page with additional links for Adults 20-64, Adult 65 and older, and Adult Immunization Schedule. The links for Adults 20-64 and Adult 65 and older state the guidelines were retired in October 2017.
  - The prenatal care guideline was retired in July 2017.
- A few behavioral health guidelines were received in the desk materials and listed on the website but there does not appear to be a guideline specifically addressing preventive behavioral health.
- The following issues were identified in reviewing the Clinical Practice Guidelines:
  - Differences exist between what is listed on the website versus information CCME received in the desk materials; i.e. the website shows Chronic Kidney Disease, Detox and substance abuse, and Opioid Management; these were not addressed in the desk materials.

- At the time of the review, the following CPGs received in the desk materials require the user to be a member to view the guideline: Depression, Heart Failure, and Obesity.

Quality Improvement Plans

- Ensure credentialing/recredentialing files contain proof of query of the Termination for Cause List.
- Ensure hospital admitting arrangements are addressed for all providers during the credentialing/recredentialing process.
- Update Policy MHSC CR-02, Assessment of Organizational Providers, to reflect the need to query the Termination for Cause List and ensure credentialing/recredentialing files for organizational providers contain proof of query of the Termination for Cause List.
- Update Policy MHSC CR_01, Credentialing Program Policy, to include the Termination for Cause List as being queried for ongoing monitoring.
- Update or remove language in Policy MHSC CR-01, Credentialing Program Policy, that discusses the Corporate Credentialing Department performing quarterly audits of practitioner information against information in the Practitioner Directory.
- Verify the preventive health guidelines for Children up to 24 Months and Children 2-19 Years are accessible and update the retired guidelines.
- Verify the clinical practice guidelines listed on the website are the same guidelines referenced in Molina materials and validate links to guidelines take the user to the specific adopted guideline.

Recommendations

- Update Policy MHSC CR-01, Credentialing Program Policy to remove references to Addendum A, Practitioner Criteria and Primary Source Verification Table.
- Update the Quality Improvement (QI) Program Description to reflect the correct name for the PRC.
- Follow-up with providers who failed the Accessibility of Services Study, consider remeasuring those providers, and document implemented actions for non-compliance.
- Implement processes to improve overall member access to providers.
- Consider adopting a behavioral health preventive guideline.

C. Member Services

CCME conducted a review of Member Services encompassing processes and requirements related to member rights and responsibilities; member education related to the MCO

program, preventive health, and chronic disease management; member disenrollment, grievances, and surveys of member satisfaction.

Molina provides a welcome packet containing instructions for accessing the Member Handbook and Provider Manual, the Notice of Privacy Practices, and a welcome letter to new members within 14 calendar days of receiving the eligibility file. Members can access the Member Handbook on Molina's website or can contact the Member Services Call Center to request a copy via mail. The Member Handbook defines covered benefits, includes Member Rights and Responsibilities, and provides information about obtaining prescriptions and urgent or emergent care in an easy to understand format. The Member Handbook and other member materials are available in Spanish or alternate formats upon request, and Molina maintains a Change Control Record for the Member Handbook on its website. CCME identified instances of erroneous and missing information in the Member Handbook and discussed the corrections needed. The corrections are detailed in the Weaknesses section of this report.

Member Services Call Center functions are conducted by staff in Texas, Michigan, and California. Updates to member benefits, services, policies, etc. are communicated to Call Center staff by the Government Contracts Department or Compliance Department, and searchable databases allow Call Center staff to quickly retrieve information specific to caller needs. The toll-free Member Services telephone number routes calls to Interactive Voice Response (IVR) menus so callers can reach appropriate staff. After hours, the IVR provides instructions to call 911 for an emergency, normal operating hours, and an option to leave confidential voicemail for Member Services or Care Management staff. Callers also have the option to transfer to the 24-hour Nurse Advice Line.

Molina has not developed written policies/procedures or a program description defining processes and requirements related to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program; however, the *SCDHHS Contract, Section 4.2.10.1*, requires written policies and procedures for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible Medicaid Managed Care Program children and young adults. Based on discussion during the onsite visit, Molina provided evidence that it is conducting appropriate monitoring and tracking of EPSDT-eligible members.

Molina hosts community events for both members and non-members throughout South Carolina. Some events are co-branded with other organizations, enhancing awareness of and attendance at the events. Various methods are used to advertise the community events, including flyers, billboards, notices placed in churches and provider offices, and email. Health screenings are offered during some of the events, and attendance is documented for all events.

A certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor, SPH Analytics, conducts Molina's annual Member Satisfaction Surveys. Although the actual sample sizes for the survey were adequate and met the NCQA minimum sample size and number of valid surveys, the response rates for both the Adult and Child surveys fell below NCQA's target of 40%. CCME provided recommendations to increase the response rates for future surveys. Results of the CAHPS survey are distributed to providers and presented to the Quality Improvement Committee (QIC).

Established policies and procedures guide staff in the handling and resolution of member grievances. Minor issues in the documentation of grievance processes and requirements are noted in the policies/procedures as well as the Member Handbook and Provider Manual. A review of the grievance files reflected timely acknowledgement, review by appropriate staff, and timely resolution. In several files, the grievance was referred to another internal department for investigation and resolution; however, the file did not contain documentation of the findings or actions taken by the other departments to resolve the grievance.

As noted in *Figure 5: Member Services Findings*, 88% of the standards for Member Services are scored as "Met." Scores of "Partially Met" are related to documentation of benefit and co-payment information in the Member Handbook and Provider Manual, lack of a policy addressing EPSDT requirements, and documentation related to grievance requirements and processes.

Figure 5: Member Services Findings

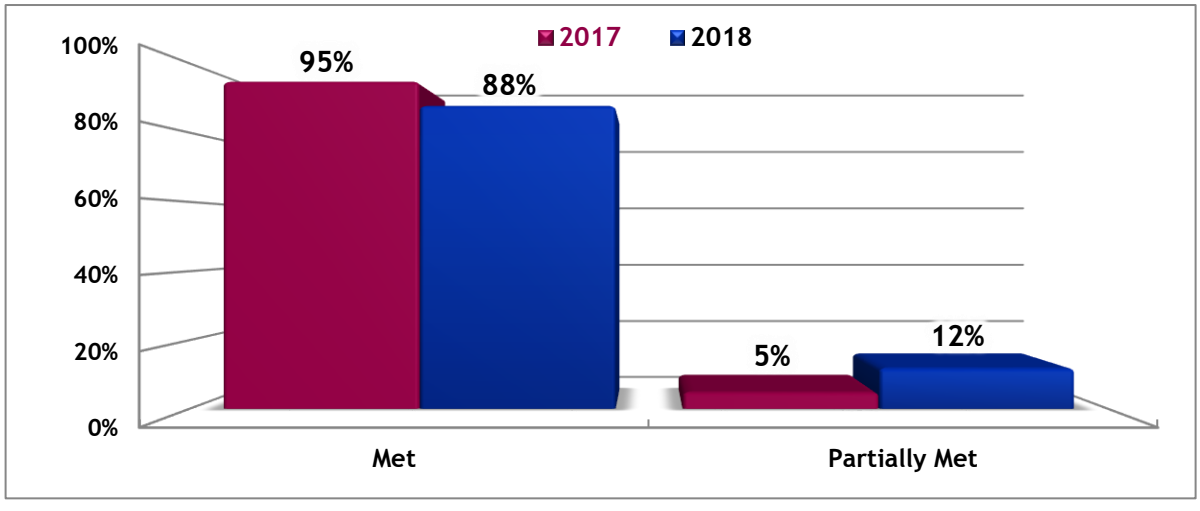


Table 5: Member Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Preventive Health and Chronic Disease Management Education	The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits	Met	Partially Met
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: definition of a grievance and who may file a grievance	Met	Partially Met
	Timeliness guidelines for resolution of the grievance as specified in the contract	Met	Partially Met
	Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The home page of Molina's website features "Quick Tools for Members" that allow members to navigate to various online functions quickly. The tools include searching for a provider, changing the assigned PCP, requesting new ID cards, and viewing personal health records.
- Molina's website provides a secure Member Portal that provides members with the ability to request ID cards, change providers, get health reminders, check coverage of prescription drugs, and view claims history and medical profile (assessments, conditions, care plans, etc.). The secure portal can be accessed from computers and smart phones.
- The free HealthinHand app for smart phones provides members with a means of managing their health care using their MyMolina User ID and Password to access secure features including viewing ID cards, finding a doctor or facility, contacting the Nurse Advice Line, etc.

Weaknesses

- Issues noted in the documentation of benefits information include:
  - Page 31 of the Member Handbook indicates hysterectomies, sterilizations, and abortions are "Covered when they are non-elective and medically necessary." However, sterilizations are generally elective, and abortions under specific circumstances are elective, coverable services.
  - Page 35 of the Member Handbook and page 22 of the Provider Manual reference a four-prescription limit per month; however, the limit of four prescriptions per month was eliminated July 1, 2017. Refer to *SCDHHS Medicaid Bulletin MB# 17-014*.
  - Page 37 of the Member Handbook addresses Rehabilitative Services for Children but does not indicate this benefit applies to non-hospital-based services. Refer to the *SCDHHS Contract, Section 4.2.23*.
  - The Provider Manual does not include information regarding coverage of chiropractic services.
  - Page 22 of the Provider Manual indicates adult well visits are covered every two years; however, CCME confirmed during onsite discussion that Molina has no limitations on the frequency of adult well visits.
  - The Member Handbook does not include information stating that female members may access a women's health specialist for routine and preventive health services in addition to the member's PCP. Refer to the *SCDHHS Contract, Section 6.1.6*.
- CCME confirmed during onsite discussion that prior authorization is required for a member to obtain a second opinion from an out-of-network provider; this is not indicated on page 41 of the Member Handbook.
- The Provider Manual defines copayment requirements but does not include the $3.40 co-payment for dental services.
- A table in the Member Handbook (pages 43-44) includes recommended services for age ranges, but the periodicity table is not included in the Member Handbook.
- CCME confirmed during onsite discussions that Molina does not have a policy defining processes and requirements for the EPSDT Program. The *SCDHHS Contract, Section 4.2.10.1*, requires written policies and procedures for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible Medicaid Managed Care Program children and young adults.
- The response rates for the Member Satisfaction Survey are below the NCQA target of 40%.
- Issues regarding who may file a grievance include:

- Policy MHSC-MIRR-001, Grievance Disposition Process, states a provider or a member's authorized representative acting on behalf of the member with the member's written consent may file a grievance. The corresponding procedure does not indicate a provider can file a grievance on behalf of a member or that written consent is required.
- Page 52 of the Member Handbook indicates a person the member chooses can file a grievance but does not indicate written consent is required.

- Policy and Procedure MHSC MS-18, Member Grievances, states grievances are investigated and responded to within five business days which may lead staff to believe the final resolution should be issued to the grievant within five business days.
- Page 52 of the Member Handbook and page 118 of the Provider Manual indicate that if a member requests an extension of the grievance resolution timeframe Molina must be able to explain to SCDHHS how the delay is in the member's interest; however, Molina must be able to explain the necessity of an extension only when the extension is requested by Molina, and not when requested by the member/authorized representative. Refer to the *SCDHHS Contract, Section 9.1.6.1.4*.
- Grievance files that were referred to other departments for investigation do not contain documentation of the grievance investigation or findings.

Quality Improvement Plans

- Correct the documentation of benefit information as follows:
  - Clarify the statement on page 31 of the Member Handbook regarding coverage of sterilizations and abortions.
  - Remove the documentation of the four-prescription limit per month in the Member Handbook and Provider Manual.
  - Update the Member Handbook to indicate that the Rehabilitative Services for Children benefit applies to non-hospital-based services.
  - Include information regarding coverage of chiropractic services in the Provider Manual.
  - Remove the erroneous information in the Provider Manual that adult well visits are only covered every two years.
  - Update the Member Handbook to include information denoting that female members may receive women's routine and preventive care from a women's health specialist in addition to services provided by their PCP.
  - Revise the Provider Manual to include the co-payment of $3.40 for dental services.

- Develop a policy/procedure or EPSDT Program Description to define the EPSDT Program and Molina's processes to monitor and encourage member participation in recommended EPSDT services.
- Revise Procedure MHSC-MIRR-001, Grievance Disposition Process, to include that providers may file a grievance on a member's behalf with written consent.
- Update the Member Handbook to include that written consent is required for another person to file a grievance on the member's behalf.
- Revise Policy and Procedure MHSC MS-18, Member Grievances, to reflect the 90-day resolution timeframe for grievances.

Recommendations

- Revise page 41 of the Member Handbook to indicate prior approval is needed for a second opinion with an out of network provider.
- Include the periodicity table for well-care services and screenings in the Member Handbook.
- Continue working with SPH Analytics to increase Member Satisfaction Survey response rates. Possible interventions for increasing response rates include adding reminders to call center scripts, maximizing the oversampling, and allowing a longer timeline for additional reminders to be sent and to conduct phone call surveys. Decide upon and document an internal goal to increase response rates (such as a 3% increase each year).
- Update the Member Handbook and Provider Manual to reflect that Molina must be able to explain the necessity of a grievance resolution timeframe extension only for extensions requested by Molina.
- Ensure grievance files reflect investigations and findings when reviewed by staff in other Molina departments.

D. Quality Improvement

CCME reviewed the Quality Improvement (QI) Program Description, program evaluation, committee minutes, policies, performance measures and performance improvement project validation that comprise plan QI requirements.

Molina provided the 2017 Medicaid Quality Improvement Program Description as evidence the program is designed to provide the structure and key processes for ongoing improvements of care and services Molina provides to members and providers. The program description was reviewed and approved by the Quality Improvement Committee and Molina's Board of Directors.

The Quality Improvement Committee (QIC) is responsible for the implementation and ongoing monitoring of the QI program. The QIC reviews data from QI activities to verify plan performance meets required standards and makes improvement recommendations. The QIC is chaired by the Chief Medical Officer, Dr. Shafer, and membership includes senior leadership, department directors, and seven network providers. The QIC meets at least quarterly and a quorum of 60% of the members with no less than three network providers is needed to enact or implement decisions. In 2017 this committee met four times. The meetings were well attended by network providers and minutes for each meeting are documented comprehensively.

Annually, Molina evaluates the effectiveness of the QI program. Molina provided the Quality Improvement Program 2016 Annual Evaluation with the desk materials. The 2017 Annual Evaluation is a draft and will be presented to the QIC and Board of Directors for review and approval upon completion.

Performance Measure Validation

CCME conducted a validation review of the Health Effectiveness Data Information Set (HEDIS®) performance measures following CMS developed protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

Molina uses Inovalon, a certified software organization, to calculate HEDIS rates. The comparison from the previous to the current year revealed a strong increase in Asthma Medication Ratio and Metabolic Monitoring for Children and Adolescents on Antipsychotics. The measures that decreased are the Statin Therapy for Patients With Cardiovascular Disease and Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia. *Table 6, HEDIS Performance Measure Data displays t*he change in rates from the previous to the current year.

Table 6: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	83.59%	84.79%	1.20%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	59.60%	62.47%	2.87%
Counseling for Nutrition	47.24%	49.23%	1.99%
Counseling for Physical Activity	41.28%	43.27%	1.99%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
Childhood Immunization Status (cis)			
DTaP	66.89%	65.56%	-1.33%
IPV	86.31%	81.68%	-4.63%
MMR	83.66%	86.31%	2.65%
HiB	79.91%	75.28%	-4.63%
Hepatitis B	85.87%	81.24%	-4.63%
VZV	86.09%	86.75%	0.66%
Pneumococcal Conjugate	70.64%	68.21%	-2.43%
Hepatitis A	80.57%	82.12%	1.55%
Rotavirus	69.09%	64.90%	-4.19%
Influenza	34.22%	32.23%	-1.99%
Combination #2	62.03%	60.71%	-1.32%
Combination #3	59.60%	57.84%	-1.76%
Combination #4	57.62%	56.73%	-0.89%
Combination #5	50.77%	50.55%	-0.22%
Combination #6	26.49%	23.40%	-3.09%
Combination #7	49.67%	50.11%	0.44%
Combination #8	26.27%	23.40%	-2.87%
Combination #9	22.96%	21.19%	-1.77%
Combination #10	22.96%	21.19%	-1.77%
Immunizations for Adolescents (ima)			
Meningococcal	63.94%	69.09%	5.15%
Tdap	81.64%	86.98%	5.34%
HPV		16.56%	NA
Combination #1	62.17%	68.21%	6.04%
Combination #2		15.01%	NA
Lead Screening in Children (lsc)	61.37%	65.12%	3.75%
Breast Cancer Screening (bcs)	NR	NR	NA

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
Cervical Cancer Screening (ccs)	59.37%	56.31%	-3.06%
Chlamydia Screening in Women (chl)			
16-20 Years	46.44%	52.27%	5.83%
21-24 Years	61.67%	65.23%	3.56%
Total	49.49%	55.24%	5.75%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	74.19%	74.14%	-0.05%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	NR	29.14%	NA
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	61.28%	56.77%	-4.51%
Bronchodilator	74.41%	71.88%	-2.53%
Medication Management for People With Asthma (mma)			
5-11 Years: Medication Compliance 50%	51.64%	50.24%	-1.40%
5-11 Years: Medication Compliance 75%	22.18%	25.18%	3.00%
12-18 Years: Medication Compliance 50%	47.32%	46.64%	-0.68%
12-18 Years: Medication Compliance 75%	18.58%	20.39%	1.81%
19-50 Years: Medication Compliance 50%	52.53%	52.34%	-0.19%
19-50 Years: Medication Compliance 75%	34.34%	28.04%	-6.30%
51-64 Years: Medication Compliance 50%	69.23%	75.61%	6.38%
51-64 Years: Medication Compliance 75%	51.28%	48.78%	-2.50%
Total: Medication Compliance 50%	50.66%	49.97%	-0.69%
Total: Medication Compliance 75%	22.49%	24.53%	2.04%
Asthma Medication Ratio (amr)			
5-11 Years	74.18%	80.09%	5.91%
12-18 Years	61.42%	68.79%	7.37%
19-50 Years	46.36%	51.32%	4.96%
51-64 Years	46.67%	56.92%	10.25%
Total	66.38%	72.75%	6.37%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	48.88%	45.97%	-2.91%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	81.82%	71.43%	-10.39%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy: 21-75 Years (Male)	77.61%	74.26%	-3.35%
Statin Adherence 80%: 21-75 Years (Male)	72.36%	56.00%	-16.36%
Received Statin Therapy: 40-75 Years (Female)	73.21%	70.30%	-2.91%
Statin Adherence 80%: 40-75 Years (Female)	65.69%	53.45%	-12.24%
Received Statin Therapy: Total	75.10%	72.48%	-2.62%
Statin Adherence 80%: Total	69.09%	54.89%	-14.20%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	90.95%	88.96%	-1.99%
HbA1c Poor Control (>9.0%)	43.49%	50.99%	7.50%
HbA1c Control (<8.0%)	46.80%	40.62%	-6.18%
HbA1c Control (<7.0%)			
Eye Exam (Retinal) Performed	50.33%	59.16%	8.83%
Medical Attention for Nephropathy	93.82%	92.72%	-1.10%
Blood Pressure Control (<140/90 mm Hg)	52.32%	50.11%	-2.21%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	55.96%	58.00%	2.04%
Statin Adherence 80%	47.43%	49.10%	1.67%
Effectiveness of Care: Musculoskeletal Conditions			
Disease-Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	70.30%	68.32%	-1.98%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	40.56%	40.65%	0.09%
Effective Continuation Phase Treatment	25.67%	25.78%	0.11%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	42.11%	45.69%	3.58%
Continuation and Maintenance (C&M) Phase	55.72%	55.81%	0.09%
Follow-Up After Hospitalization for Mental Illness (fuh)			
30-Day Follow-Up	52.02%	60.60%	8.58%
7-Day Follow-Up	35.24%	41.76%	6.52%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
30-Day Follow-Up	N/A	56.24%	NA
7-Day Follow-Up	N/A	37.89%	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
30-Day Follow-Up: 13-17 Years	N/A	21.05%	NA
7-Day Follow-Up: 13-17 Years	N/A	13.16%	NA
30-Day Follow-Up: 18+ Years	N/A	14.58%	NA
7-Day Follow-Up: 18+ Years	N/A	10.50%	NA
30-Day Follow-Up: Total	N/A	15.22%	NA
7-Day Follow-Up: Total	N/A	10.76%	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	81.27%	78.70%	-2.57%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	62.37%	68.97%	6.60%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	72.73%	58.33%	-14.40%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	58.89%	71.67%	12.78%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	NR	50.00%	NA
6-11 Years	14.29%	27.78%	13.49%
12-17 Years	21.33%	25.23%	3.90%
Total	18.53%	26.29%	7.76%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
ACE Inhibitors or ARBs	89.19%	88.86%	-0.33%
Digoxin	44.83%	46.15%	1.32%
Diuretics	89.31%	88.45%	-0.86%
Total	88.88%	88.37%	-0.51%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	3.19%	2.31%	-0.88%
Appropriate Treatment for Children With URI (uri)	81.50%	82.09%	0.59%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	23.80%	25.71%	1.91%
Use of Imaging Studies for Low Back Pain (lbp)	71.49%	66.21%	-5.28%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	0.00%	0.00%	0.00%
6-11 Years	2.86%	0.00%	-2.86%
12-17 Years	0.56%	0.59%	0.03%
Total	1.41%	0.37%	-1.04%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	78.55%	77.24%	-1.31%
45-64 Years	88.34%	88.56%	0.22%
65+ Years	100.00%	100.00%	0.00%
Total	82.16%	81.06%	-1.10%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.48%	95.95%	-1.53%
25 Months - 6 Years	86.10%	85.89%	-0.21%
7-11 Years	89.24%	89.54%	0.30%
12-19 Years	87.54%	88.60%	1.06%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: 13-17 Years	38.58%	38.37%	-0.21%
Engagement of AOD Treatment: 13-17 Years	17.77%	24.42%	6.65%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
Initiation of AOD Treatment: 18+ Years	37.02%	35.51%	-1.51%
Engagement of AOD Treatment: 18+ Years	7.46%	7.91%	0.45%
Initiation of AOD Treatment: Total	37.19%	35.80%	-1.39%
Engagement of AOD Treatment: Total	8.61%	9.61%	1.00%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	83.14%	89.83%	6.69%
Postpartum Care	66.05%	70.72%	4.67%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	100.00%	0.00%	NA
6-11 Years	62.12%	64.91%	2.79%
12-17 Years	60.22%	58.02%	-2.20%
Total	61.49%	60.00%	-1.49%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	2.77%	1.99%	-0.78%
21-40 Percent	2.31%	1.49%	-0.82%
41-60 Percent	4.39%	3.23%	-1.16%
61-80 Percent	11.09%	9.93%	-1.16%
81+ Percent	79.45%	83.37%	3.92%
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.32%	0.68%	-0.64%
1 Visit	1.99%	1.58%	-0.41%
2 Visits	2.21%	4.07%	1.86%
3 Visits	6.40%	3.17%	-3.23%
4 Visits	10.82%	12.22%	1.40%
5 Visits	18.76%	17.42%	-1.34%
6+ Visits	58.50%	60.86%	2.36%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	56.89%	57.85%	0.96%

MEASURE/DATA ELEMENT	Measure Year 2015	Measure Year 2016	PERCENTAGE POINT DIFFERENCE
Adolescent Well-Care Visits (awc)	42.70%	40.62%	-2.08%

NB: Not a benefit; NR: Not reported; NA: Data not available

Performance Improvement Project Validation

CCME validated PIPs in accordance with CMS protocol *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population
- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

Four PIPs were submitted for validation. One was retired and two of the three active projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. They included Well Care (Clinical) and Improving Claims Accuracy and Provider Satisfaction. *Table 7, Performance Improvement Project Validation Scores* provides and overview of each project's validation score.

TABLE 7: Performance Improvement Project Validation Scores

PROJECT	2016 VALIDATION SCORE	2017 VALIDATION SCORE
Well Care (Clinical)	125/131= 95% High Confidence in Reported Results	99/105=94% High Confidence in Reported Results
Improving Claims Accuracy and Provider Satisfaction (Non-Clinical)	Not previously validated	57/78=73% Confidence in Reported Results

One of the projects, Well Care (Clinical), was submitted last year and validated again this year. During the onsite meeting, it was noted that telephonic outreach occurred in 2017, and that Molina has seen increased compliance. Also, the HEDIS Appointment Team is now part of Member Services. This information is not documented in the PIP form. For the Provider Satisfaction PIP, Molina noted during the onsite visit that the interventions section of the documentation needs to be updated with the most recent initiations. The

recommendations for each of the two PIPs are displayed in *Table 8, Performance Improvement Project Errors and Recommendations*.

TABLE 8: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Provider Satisfaction	Did the study use objective, clearly defined, measurable indicators?	Quantifiable Measures are defined on pages 2-4. The baseline goal is higher than the benchmark; this is not a valid measure.	Revise this section to reflect the baseline goal as the goal rate for the baseline measurement period or rate within a reasonable amount of time. The benchmark rate is the target rate or best practice rate for the completion of the PIP.
	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	No interventions were initiated based on the baseline results.	Interventions based on baseline rates should be documented.
	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented clearly. The baseline goal rate should reflect some improvement over the current state; the benchmark rate should be the target goal for the PIP.	Adjust Data/Results table to reflect appropriate baseline goal and benchmark rates.
	Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result?	Analysis for each measure at baseline was not provided in the report.	Include analysis of baseline results in comparison to baseline goal in narrative format in the report.

Project	Section	Reasoning	Recommendation
Well Care (Clinical)	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Member, Provider, and Department interventions were undertaken, although the analyses conducted suggested that gift cards are not a successful method for motivating members to get well-checks.	The use of QET visits appears to positively affect the rates; however, it is not clear that gift cards increase member compliance. Initiate new interventions that are member focused to increase compliance rates for member-related barriers.
	Was there any documented, quantitative improvement in processes or outcomes of care?	As of the most recent data, the rates decreased for AWC, W34, Well Child Visits in the First 15 months of life, AAP, CAP, and WCC measures.	Continue interventions to improve rates.

Details of the validation of the performance measures and PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Finally, CCME did a preliminary review of the Breast Cancer Screening PIP although it was not validated this year. The longevity of this PIP is still showing very little positive effects on the breast cancer screening rate. The rates have increased, but the actual effect from the mobile mammogram appears to be minimal. This is reflected in the graph on the last page of the report that shows most counties have less than 5% of members who were compliant because of the mobile mammogram.

For the Interventions Table, the barriers are listed on the right and the interventions to address the barriers should be in the left column. The first part of the Table documents this correctly, but the latter part of the Table shows barriers and does not show how the interventions address those barriers. For example, on page 84 the barrier is Provider Engagement and the intervention is listed as “Hope Health- 29 eligible members that have not received a mammography.” This is not an intervention to address Provider Engagement; the Plan needs to provide more information in the intervention column. Another barrier states “Members Are Unable to Attend Mobile Mammogram Events due to Child Care Needs, Difficulty Taking Time from their Job or Additional Personal Constraints” and the intervention is a gift card. It does not seem that a gift card will help with child care needs and difficulty in taking time away from a job for health care. It also appears that the gift cards are not being redeemed. Molina may wish to consider other

interventions besides the gift cards that are member-directed to address child care needs and other constraints. In addition, the Plan needs to correct the errors in the Interventions Table. Consider discontinuing ineffective interventions and implement new interventions to address all barriers.

Figure 6, Quality Improvement Findings indicates that 93% of the standards received a "Met" score.

Figure 6: Quality Improvement Findings

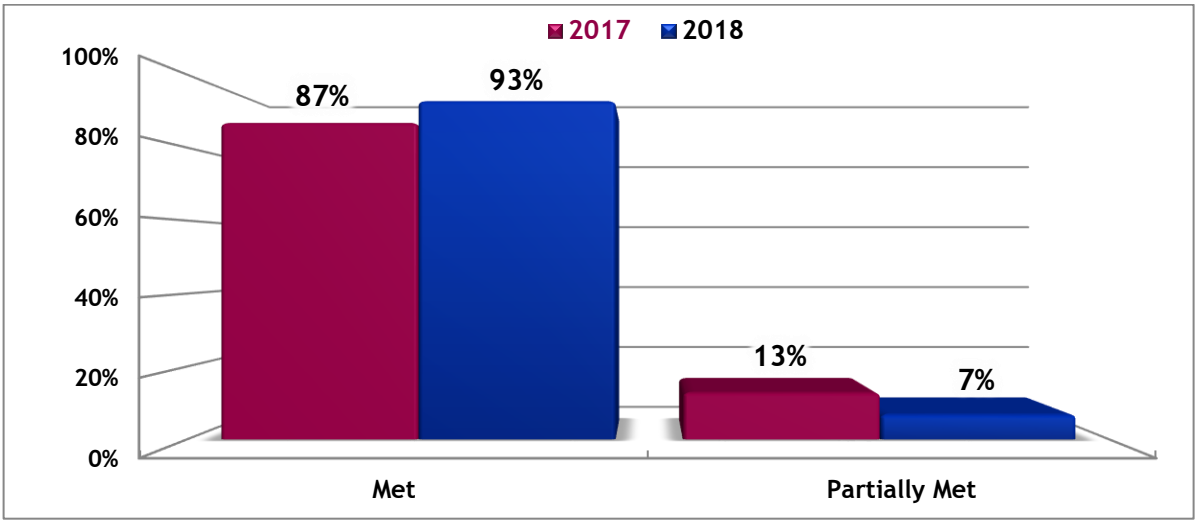


TABLE 9: Quality Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Quality Improvement Program	The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines	Partially Met	Met
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The Quality Improvement Committee meetings are well-attended by network providers. Minutes for each meeting are documented comprehensively.

Weaknesses

- The Provider Satisfaction PIP does not have documented interventions to address barriers, nor is there an analysis of the baseline data. The Well Care (Clinical) PIP rates have decreased for all measures as of the latest available data.
- The Breast Cancer Screening PIP is showing an insignificant effect on the breast cancer screening rate despite the longevity of the PIP. Interventions do not address the identified barriers.

Quality Improvement Plan

- Correct the errors identified in the Provider Satisfaction and in the Well Care (Clinical) PIP.

Recommendation

- The barriers and the interventions for the Breast Cancer Screening PIP must align. Implement new, member-directed interventions to address child care needs and other constraints, and correct the errors in the Interventions Table. Discontinue ineffective interventions and implement new interventions that address all barriers.

E. Utilization Management

Molina's Healthcare Services (HCS) Medicaid Program Description outlines and describes the Utilization Management (UM) Program. It gives an overview of the UM Department structure and methodology for conducting UM processes for SC members, and outlines the purpose, operations, and lines of responsibility within the HCS Department. Members and providers can obtain information about the UM program in several ways, such as the Member Handbook, Provider Manual, and the Molina website.

Departmental policies provide guidelines on operationalizing standards and complying with requirements. CCME identified issues with pharmacy authorization timeliness requirements and lack of documentation regarding the availability of a five-day emergency supply of medication and members' ability to obtain specialty pharmaceuticals from a local pharmacy in the Member Handbook and the Provider Manual. CCME also found the methodology for inter-rater reliability (IRR) testing is not consistent for all reviewers issuing UM determinations.

UM approval and denial files indicate decisions are made based on medical necessity criteria by the appropriate staff person in a timely manner. CCME found that denial letters do not clearly identify the physician rendering the denial and do not reference the date of service or the specific service denied.

Molina has established policies and procedures addressing standard and expedited appeals of adverse benefit determinations by members and providers. Information regarding appeals processes and requirements is also found in the Member Handbook, Provider Manual, and on the Molina website. The Molina website does not indicate that authorized representatives, acting on the member's behalf and with the member's written consent, may file appeals or that a provider may serve as a member's authorized representative and act on behalf of the member with the member's written consent. The Member Handbook does not indicate that Molina must explain the necessity of an extension only when the extension is requested by Molina, and not when requested by the member/authorized representative.

Molina's Case Management (CM) policies and procedures, as well as the HCS Medicaid Program Description, provide guidance to staff performing CM activities; CCME provided several recommendations to improve the information found in the policies and procedures. Case Management files reflect appropriate activities are being conducted.

As noted in *Figure 7, Utilization Management Findings* Molina received "Met" scores for 93% of the UM standards. Standards that received a score of "Partially Met" are addressed in the Weaknesses section below.

Figure 7: Utilization Management Findings

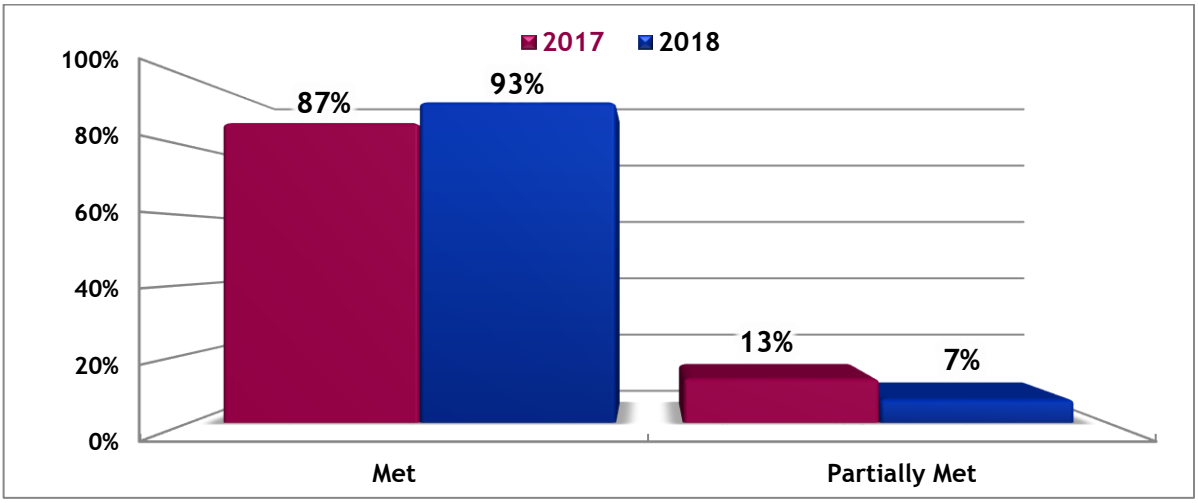


TABLE 10: Utilization Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met
Medical Necessity Determinations	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Partially Met	Met
	Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Partially Met
	Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Partially Met	Met
Appeals	The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including the definitions of an action and an appeal and who may file an appeal	Partial Met	Met
	The procedure for filing an appeal	Partial Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partial Met	Met
	Written notice of the appeal resolution as required by the contract	Met	Partial Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Case Management files reflect Molina uses available resources to provide quality services to members.

Weaknesses

- Onsite discussion revealed Molina changed the pharmacy determination timeframe from 24 hours to 14 days based on instructions received from SCDHHS and evidence of that instruction was provided to CCME. Procedure MHSC-PHARM-02, Pharmacy Prior Authorization Requests, notes coverage determinations are made within 14 calendar days; however, page 45 of the Member Handbook and page 41 of the Provider Manual indicate pharmacy determinations are made within 24 hours.
- Molina has developed a Preferred Provider Program; however, providers are not consistently informed that this program is available. Molina does not have any providers in the Preferred Provider Program currently.
- Regarding inter-rater reliability (IRR), onsite discussion confirmed 30 sample files are reviewed for each pharmacy staff member and medical director. For other HCS staff, the sample of 30 files is pulled from the functional areas as a whole and not on a "per-staff-member" basis.
- The Preferred Drug List (PDL) is mentioned in the Provider Manual, page 35, but there is no direction about where the PDL is located or how to access it.
- The Member Handbook includes a reference to the PDL, but the process a member must follow to obtain OTC medications is not explained.
- The Provider Manual and Member Handbook do not address the provision of a five-day supply of medication while a prior authorization is pending. They also do not address how members in the lock-in program are provided a five-day supply of medication by a pharmacy that is not a designated lock-in pharmacy.
- For specialty pharmacy medications, the Provider Manual and Member Handbook do not communicate that Molina allows an initial supply of the medication to be provided at a local pharmacy in clinically urgent circumstances.
- Policy MHSC-HCS-UM-384, Emergency & Post Stabilization Services, does not address two of the requirements for Emergency Services as noted in the *SCDHHS Contract, Section 4.2.11.1.6* and *4.2.11.1.7* as well as in *Federal Regulation § 438.114 (c) (ii) (A)* and *Federal Regulation § 438.114 (d) (1) (ii)*:
  - The MCO may not refuse to cover emergency services based on the ER provider, hospital, or fiscal agent not notifying the member's PCP, CONTRACTOR or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.
  - The MCO may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious

jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

- The headings for section A and section B in Procedure MHSC-HCS-UM-384, Post Stabilization Review, do not clearly define the types of requests addressed by each respective section.
- Notice of Adverse Benefit Determination letters do not clearly identify the physician issuing the denial determination as required by Procedure MHSC-HCS-UM-325, Authorization Process (page four). Additionally, Notice of Adverse Benefit Determination letters do not reference the date of service or the specific service denied.
- Issues noted related to written consent for a provider or other representative to appeal on the member's behalf include:
  - The Molina website does not indicate that authorized representatives acting on the member's behalf and with the member's written consent may file appeals, or that a provider may serve as a member's authorized representative and act on the behalf of the member with the member's written consent.
  - During onsite discussion, Molina staff reported the member's consent for treatment by the provider is regarded as consent to appeal on the member's behalf. This is not reflected in the appeals policies and procedures (MHSC-MIRR-002 and MHSC-MIRR-003).
- Pages 53 and 54 of the Member Handbook indicate that if an extension of the appeal resolution timeframe is requested, Molina must be able to explain to SCDHHS how the delay is in the member's interest. Molina must be able to explain the necessity of an extension only when the extension is requested by Molina, and not when requested by the member/authorized representative.
- The *SCDHHS Contract, Section 9.1.6.3.1.3*, requires State Fair Hearings to be requested within 120 calendar days from the date of the notice of appeal resolution. The Member Handbook states the 120-day timeframe to request a State Fair Hearing begins the date the member signs for the certified letter, and the Provider Manual states the timeframe begins from the date of receipt of the determination notice.
- The HCS Medicaid Program Description, page 55, does not include sensory impaired individuals in the list of services for targeted case management.
- It is not clear if clinical or non-clinical staff are completing the initial health risk assessment (HRA) in Procedure MHSC-HCS-CM-061, Initial Health Risk Assessment. Molina staff explained that an initial HRA is not completed if the member is receiving Transition of Care Services. This exception is not noted in Procedure MHSC-HCS-CM-061, Initial Health Risk Assessment.

Quality Improvement Plan

- Revise the Provider Manual and Member Handbook to reflect pharmacy authorization determinations are made within 14 calendar days.
- Revise HCS IRR processes so that all individual reviewers are assessed using the NCQA "8/30 methodology" for file sampling.
- Revise the Member Handbook and Provider Manual to reflect the correct timeframe for requesting a State Fair Hearing.

Recommendations

- Explore opportunities to notify providers about the Preferred Provider Program, such as in the Provider Manual and during provider meetings.
- Revise the Provider Manual to reference where providers can locate the PDL.
- Update the Member Handbook to describe requirements for coverage of OTC medications.
- In the Provider Manual and Member Handbook, include information about the provision of a 5-day supply of medication when prior authorization is pending and about obtaining an initial supply of specialty medication from a local pharmacy in clinically urgent circumstances.
- Update Policy MHSC-HCS-UM-384, Post Stabilization Review - Emergent Care Visits, to include the two missing request circumstances for emergency services.
- Revise the headings for sections A and B in Procedure MHSC-HCS-UM-384, Post Stabilization Review Emergent Care Visits, to indicate these sections apply to notification of admissions.
- Revise Notice of Adverse Benefit Determination letters to include the physician issuing the denial determination or remove this process step from the procedure document.
- Revise Notice of Adverse Benefit Determination letters to include the date of service and the specific service being denied.
- Update the website to include information that authorized representatives, including providers, may file appeals with the member's written consent.
- Update the appeals policies and procedures (MHSC-MIRR-002 and MHSC-MIRR-003) to include information stating the member's consent for treatment serves as consent for the provider to appeal on the member's behalf.
- Update the Member Handbook to reflect that Molina must be able to explain the necessity of an appeal resolution timeframe extension to SCDHHS for extensions requested by Molina only.

- Include the phrase "Sensory impaired individuals" in the 2017 HCS Medicaid Program Description when listing the nine services for Targeted Case Management.
- Indicate the HCS staff who completes the initial and comprehensive HRAs and indicate the circumstances under which an HRA is not completed in Policy and Procedure MHSC-HCS-CM-061, Initial Health Risk Assessment.

F. Delegation

Molina executes written agreements with all entities performing delegated services. CCME reviewed a sample credentialing delegation addendum in the desk materials. Molina's delegated services are defined in *Table 11, Delegated Entities and Services*.

Table 11: Delegated Entities and Services

Delegated Entities	Delegated Services
Bon Secours St. Francis (BSSF), Managed Health Resources (MHR), AU Medical Center (AU), Greenville Hospital System (GHS), Medical University of South Carolina (MUSC), Regional Health Plus (RHP), March Vision Care, Mary Black Health Network, and United Physicians	Credentialing/Recredentialing

The Delegation Oversight Committee oversees delegated provider groups to ensure the delegated entities are operating in compliance with Molina's policies and procedures and applicable regulatory and accreditation standards. The committee meets at least quarterly and the Chairperson is responsible for representing the committee at the QIC meetings.

Molina has a detailed process for overseeing delegated entities that include pre-assessment audits for potential delegates, annual oversight, and ongoing monitoring of monthly and quarterly reports. When deficiencies are identified, Molina implements corrective action plans with follow-up audits, as appropriate. The processes are outlined in several policies and procedures.

CCME received proof of oversight for the delegated entities. A few issues, such as inconsistency in scoring between the entities and improper scoring, are discussed in the Weaknesses section.

As indicated in *Figure 8, Delegation Findings* one of the two standards in the Delegation section is scored as "Partially Met."

Figure 8: Delegation Findings

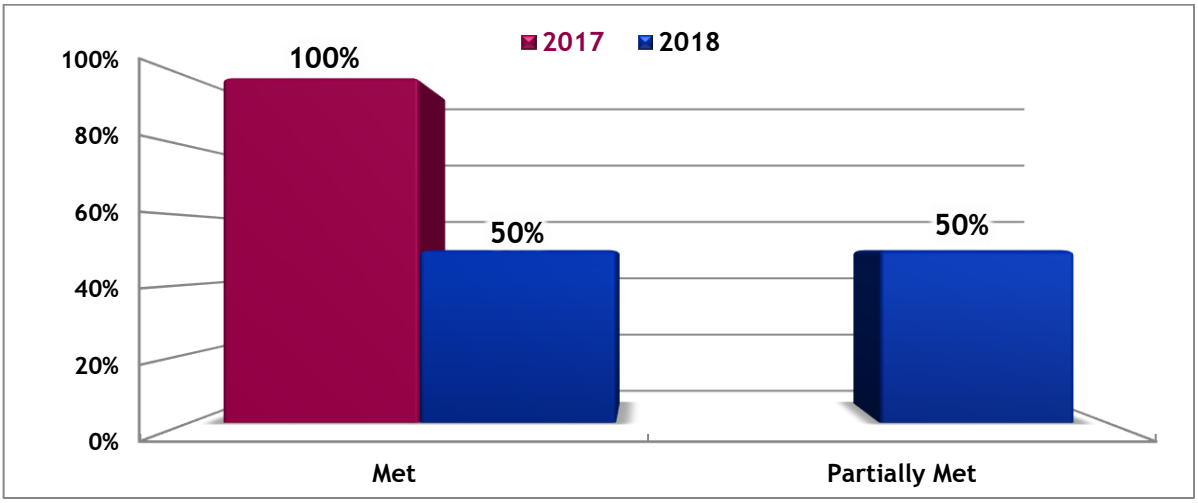


TABLE 12: Delegation Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Weaknesses

- CCME received proof of oversight for the plan's delegated entities. A few issues are discussed and noted below:
  - CCME found inconsistency in scoring between the entities related to the Social Security Death Master File (SSDMF). For some entities, (i.e., MUSC, MBHN, and United Physicians) the score in the "Policies" section of the tool for the "Sanctions Screening Procedure" indicated 100% with a note the SSDMF was not included. For other entities (i.e., AU Medical Center, GHS, BSSF) it was scored 0%, which indicated "not in compliance." Some entities had this issue as Corrective Action Items, some were Recommendations; MBHN was not included as a follow-up item even though a note indicated no record of checking the SSDMF.
  - For MUSC, the file review worksheets in the tool showed N/A for ownership disclosure form in the file, yet the overall score for the audit was 100%. During onsite discussion, Molina indicated the entity did have the ownership disclosure

forms in a different file, they were just not in the credentialing/recredentialing files. CCME questioned why they were scored N/A. It appears the entity met the requirement by obtaining the ownership disclosure forms.

Quality Improvement Plan

- CCME recommends training the delegation oversight reviewers to ensure consistency of how they review delegated entities.

G. State Mandated Services

CCME's review of State Mandated Services found that Molina provides members with the core benefits required by the *SCDHHS Contract*.

The Provider Manual defines the EPSDT services provided to members and informs that Molina's QI Department offers training to help providers follow guidelines for EPSDT/well-child services. The Provider Manual also informs that providers are monitored to verify they comply with requirements for provision of EPSDT services and immunizations.

Quality Improvement medical record review specialists conduct annual medical record reviews to assess provider compliance with the provision of EPSDT services, including immunizations, through the medical records review process.

Molina received a score of "Met" for 100 % of the standards in the State-Mandated Services, as illustrated in *Figure 9, State-Mandated Services*.

Figure 9: State-Mandated Services

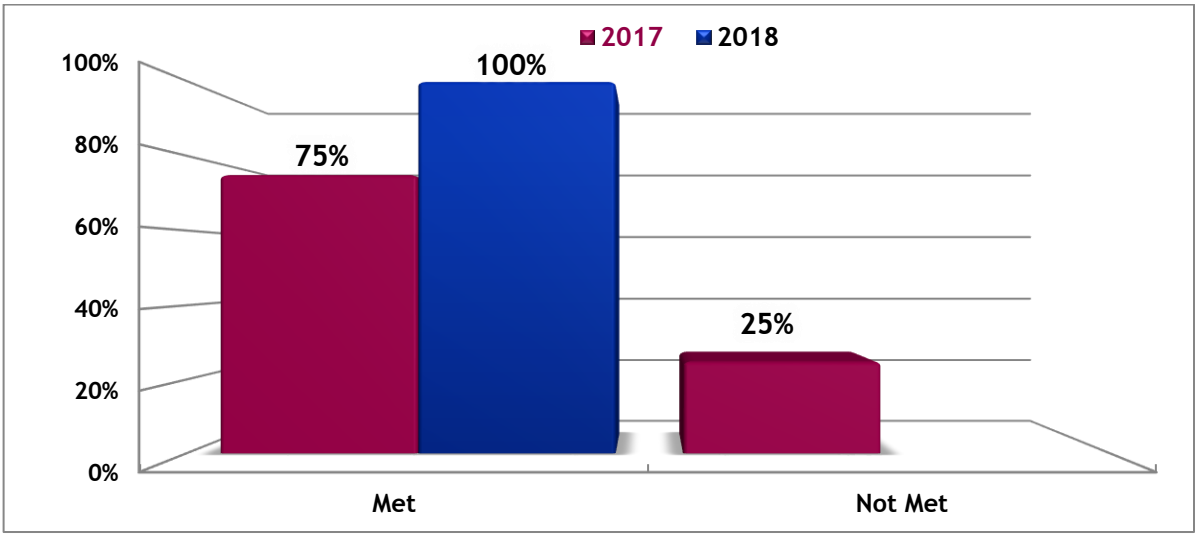


TABLE 13: State Mandated Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
State-Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

February 5, 2018

Mr. Tom Lindquist
Molina Healthcare of South Carolina
4105 Faber Place Drive, Suite 120
Charleston, SC 29405

Dear Mr. Lindquist:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2018 External Quality Review (EQR) of Molina Healthcare of South Carolina is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **April 12th and 13th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **February 19, 2018.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to schedule an education session (via webinar) on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2018

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

5. A complete list of network providers for the Healthy Connections Choices (HCC) members. The list should be submitted as an excel spreadsheet in the format listed in the table below. Specialty codes and county codes may be used however please provide an explanation of the codes used by your organization.

Excel Spreadsheet Format

List of Network Providers for Healthy Connections Choices Members	
Practitioner's First Name	Practitioner's Last Name
Practitioner's title (MD, NP, PA, etc.)	Phone Number
Specialty	Counties Served
Practice Name	Indicate Y/N if provider is accepting new patients
Practice Address	Age Restrictions

6. The total number of unique specialty providers as well as the total number of unique primary care providers currently in the network.

7. A current provider list/directory as supplied to members.

8. A copy of the current Compliance plan and organization chart for the compliance department.

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2017 and 2018.

11. The most recent reports summarizing the effectiveness of the Quality Improvement, Medical/Utilization Management, and Disease/Case Management Programs.

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for those projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e. analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

16. Copies of the most recent physician profiling activities conducted to measure contracted provider performance.

17. Results of the most recent medical office site reviews, medical record reviews and a copy of the tools used to complete these reviews.

18. A complete list of all members enrolled in the case management program from January 2017 through January 2018. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

20. A copy of the member handbook and any statement of the member bill of rights and responsibilities if not included in the handbook.

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

22. A copy of any member and provider newsletters, educational materials and/or other mailings. Include new provider orientation and ongoing provider education materials.

23. A copy of the Grievance, Complaint and Appeal logs for the months of January 2017 through January 2018.

24. Copies of all letter templates for documenting approvals, denials, appeals, grievances and acknowledgements.

25. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards.

26. Preventive health practice guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

28. A list of physicians currently available for utilization consultation/review and their specialty.

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated; i.e. credentialing, behavioral health, utilization management, external review, case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    b. reporting frequency and format;
    c. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    d. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    e. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    f. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    g. calculated and reported rates.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of January 2017 through January 2018. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of January 2017 through January 2018, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at** https://egro.thecarolinascenter.org
- **should be submitted in the categories listed**

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Most recent physician monitoring for adherence to clinical practice and preventive guidelines. Please include the medical record review audit and the claims data audit.
3. The 2017 QI Program Evaluation. Will accept the draft version if not approved.
4. QI Committee minutes for 11-2-17. The minutes in the 11-2-17 folder in the desk materials were for the 2-23-17 meeting.
5. Copy of the Practitioner Availability and Network Adequacy Analysis for 2017. Will accept draft report.
6. Delegation oversight for March Vision Care.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM VALIDATION WORKSHEET

Plan Name:	**Molina**
Name of PM:	**HEDIS**
Reporting Year:	**MY 2016**
Review Performed:	**2018**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS Technical Specifications Vol. 5

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1 Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1 Sampling	Sample was unbiased.	**MET**	
S2 Sampling	Sample treated all measures independently.	**MET**	
S3 Sampling	Sample size and replacement methodologies met specifications.	**MET**	

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Was the measure reported accurately?	**MET**	
R2 Reporting	Was the measure reported according to State specifications?	**MET**	

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	MET	5
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

Elements with higher weights are elements that, should they have problems, could result in more issues with data validity and/or accuracy.

Plan's Measure Score	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

AUDIT DESIGNATION POSSIBILITIES	
Fully Compliant	Measure was fully compliant with State specifications. *Validation findings must be 86%–100%.*
Substantially Compliant	Measure was substantially compliant with State specifications and had only minor deviations that did not significantly bias the reported rate. *Validation findings must be 70%–85%.*
Not Valid	Measure deviated from State specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required. *Validation findings below 70% receive this mark.*
Not Applicable	Measure was not reported because MCO/PIHP did not have any Medicaid enrollees that qualified for the denominator.

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**IMPROVING CLAIMS ACCURACY AND PROVIDER SATISFACTION**
Reporting Year:	2017
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	Evaluation of provider satisfaction revealed an opportunity for improvement.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in Section A on page 2.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Partially Met**	Quantifiable Measures are defined on pages 2-4. The baseline goal is higher than the Benchmark, and this should not be the case. ***Recommendation: Revise this section to reflect the baseline goal as the goal rate for the baseline measurement period. The benchmark rate is the target rate for the completion of the PIP.***
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to processes of care.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.

Component / Standard (Total Points)	Score	Comments
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling was not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling was not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling was not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected are specified in Section C.1 and C.2.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources are specified in Section C.1.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Survey, claims, complaints data are documented in Section C.2.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Using continuous data collection cycle as shown in Section C.4.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis continuous in Section C.4.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are documented.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Not Met**	No interventions have been initiated based on the baseline results. ***Recommendation: Document interventions based on baseline rates.***
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are performed on continuous basis.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Partially Met**	Results are presented clearly. The baseline goal rate should reflect some improvement over the current state; the benchmark rate should be the target goal for the PIP. ***Recommendation: Adjust Data/Results table to reflect appropriate baseline goal and benchmark rates.***

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Only baseline rates are available.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Not Met**	Analysis for each measure at baseline is not provided in the report. ***Recommendation: Include narrative format of analysis of baseline results in comparison to baseline goal in the report.***
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**NA**	Only baseline rates are available.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	Cannot judge because baseline rates are the only measurement.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Cannot judge because baseline rates are the only measurement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Cannot judge because baseline rates are the only measurement.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Cannot judge because baseline rates are the only measurement.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score	Steps	Possible Score	Score
Step 1			Step 6		
1.1	5	5	6.4	5	5
1.2	1	1	6.5	1	1
1.3	1	1	6.6	5	5
Step 2			Step 7		
2.1	10	10	7.1	10	0
Step 3			Step 8		
3.1	10	5	8.1	5	5
3.2	1	1	8.2	10	5
Step 4			8.3	NA	NA
4.1	5	5	8.4	1	0
4.2	1	1	Step 9		
Step 5			9.1	NA	NA
5.1	NA	NA	9.2	NA	NA
5.2	NA	NA	9.3	NA	NA
5.3	NA	NA	9.4	NA	NA
Step 6			Step 10		
6.1	5	5	10.1	NA	NA
6.2	1	1	Verify	NA	NA
6.3	1	1			

Project Score	57
Project Possible Score	78
Validation Findings	73%

AUDIT DESIGNATION
Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**Molina**
Name of PIP:	**WELL-CARE PROGRAM**
Reporting Year:	2017
Review Performed:	2018

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**Met**	HEDIS measure evaluation revealed an opportunity for improvement.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**Met**	The plan addresses a broad spectrum of enrollee care and services.
1.3 Did the MCO's/PIHP's PIPs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**Met**	No relevant populations were excluded.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**Met**	Question was clearly stated in Section A on page 2.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**Met**	Quantifiable Measures are defined on pages 8-15.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**Met**	Measures are related to health status and processes of care and have strong associations with improved outcomes.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**Met**	Population is clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**Met**	Population studied was intended population.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**Met**	Sampling technique considered CI and margin of error.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**Met**	HEDIS specifications for sampling were followed.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**Met**	Sample contained a sufficient number of enrollees.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**Met**	Data to be collected are specified in Section C.1 and C.2.
6.2 Did the study design clearly specify the sources of data? **(1)**	**Met**	The sources are specified in Section C.1.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**Met**	Programmed pull documented in Section C.2.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**Met**	Using continuous data collection cycle as shown in Section C.4.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**Met**	Data analysis once per year in Section C.4.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**Met**	Qualifications of personnel are documented in Section C.2
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**Partially Met**	Member, Provider, and Department interventions were undertaken, although the analyses conducted suggest that gift cards are not a successful method for motivating members to get well-checks. ***Recommendations: The use of QET visits appears to positively affect the rates; however, it is not clear that the gift cards increase member compliance. Initiate new, member-focused interventions to increase compliance rates for member-related barriers.***
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**Met**	Analyses are performed yearly as indicated in data analysis plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**Met**	Results are presented clearly.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**Met**	Initial and repeat measurements were shown in the report.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**Met**	Analysis for each measure at each measurement period is provided in the report.

Component / Standard (Total Points)	Score	Comments
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**Met**	The same methodology was used at all measurement points.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**Not Met**	The rates decreased for AWC, W34, Well Child Visits in the First 15 months of life, AAP, CAP, AND WCC measures; however, the final rates for most recent remeasurement are not available until July 2018. This item cannot be fully evaluated. ***Recommendation: Continue interventions to improve rates.***
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Six of the eight measures have measurements, but only one remeasurement. Two of the measures only have baseline data, thus sustained improvement cannot be evaluated.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Data not available for full measurement periods.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	5
Step 2				Step 7		
2.1	10	10		7.1	10	5
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	10
Step 4				8.3	1	1
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	5	5		9.2	1	0
5.2	10	10		9.3	NA	NA
5.3	5	5		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	NA	NA
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	99
Project Possible Score	105
Validation Findings	94%

AUDIT DESIGNATION
High Confidence in Reported Results

AUDIT DESIGNATION POSSIBILITIES	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR Survey Validation Worksheet

Plan Name	**MOLINA**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2017
Review Performed	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 1,671. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol are clear, and align with requirements. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 26.9% (n=449 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, although the response rate is below the NCQA target rate. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS* ***Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.***

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan is in place. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures are followed. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data are analyzed. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS; 2016 QI Eval.*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests are conducted. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions are supported by findings. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 26.9%. The target response rate according to NCQA is 40.0%, thus, caution should be used when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Regarding composite scores: Getting Needed Care: 52nd percentile Getting Care Quickly: 50th percentile How Well Doctors Communicate: 94th percentile Customer Service 63rd Shared Decision Making: 61st percentile Customer Service received lowest score, and Shared Decision Making received the highest scores. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Access, quality, and timeliness are reported in the survey. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information is provided and documented. Documentation: *2017 CAHPS MEDICAID ADULT 5.0H FINAL REPORT --- SPH ANALYTICS*

CCME EQR Survey Validation Worksheet

Plan Name	**MOLINA**
Survey Validated	**CAHPS CHILD (AND CHILD CCC) 5.0H**
Validation Period	2017
Review Performed	2018

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

ACTIVITY 1: REVIEW SURVEY PURPOSE(S), OBJECTIVE(S) AND INTENDED USE

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 2: ASSESS THE RELIABILITY AND VALIDITY OF THE SURVEY INSTRUMENT

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population is clearly defined. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame are clearly defined. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**NOT MET**	The required sample size is 3,490 according to NCQA. Molina has a sample size of 2,393 Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS* ***Recommendation: Work with SPH to increase the sample size for eligible respondents.***
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures are used to select the sample. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates are aligned with NCQA protocol, are clear, and align with requirements. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate is 24.7% (n=583 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, although the response rate is below the NCQA target rate. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS* ***Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.***

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan is in place. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures are followed. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data are analyzed. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS; 2016 QI EVal*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests are conducted. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions are supported by findings. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS; 2016 QI Eval*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - SPH Analytics as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses are noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate is 24.7%. The target response rate according to NCQA is 40.0%, thus, caution should be used when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	<u>*General Population (using Quality Compass)*</u> Getting Needed Care:62nd percentile Getting Care Quickly:63rd percentile How Well Doctors Communicate: 53rd percentile Customer Service: 71st percentile Shared Decision Making: 60th percentile Health Promotion and Education:45th percentile Ease of Filling out Forms:18th percentile Ease of Filling Out Forms is area with highest need for improvement, followed by Health Promotion and Education.
		Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness of care is part of the CAHPS 5.0 survey. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information is provided and documented in report. Documentation: *2017 CAHPS MEDICAID CHILD 5.0H FINAL REPORT --- SPH ANALYTICS*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Molina Healthcare of SC**
Collection Date:	**2018**

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Molina Healthcare of South Carolina (Molina) uses policies and procedures to define business practices. Policy MHSC-AD-02, Annual Policy Review, establishes the requirement that all policies and procedures be reviewed on an annual basis. Updates to policies and procedures are taken to the Administrative and Policy (A&P) Committee in addition to other business unit governing committee(s) as required for review and approval.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Dora Wilson is the Interim Plan President for Molina Healthcare of South Carolina. She is responsible for the day-to-day business activities and reports to the local Board of Directors and the Molina Regional Vice President in Michigan. Onsite discussion confirmed that Molina is actively working to fill the Plan President position vacancy.
1.2 Chief Financial Officer (CFO);	X					The Vice President of Finance and Analytics is Adriana Day, CPA.
1.3 * Contract Account Manager;	X					The Associate Vice President of Government Contracts is Nicole Melton-Mitchell. She also serves as the Contract Account Manager and is located in SC.
1.4 Information Systems personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Plan oversight of claims functions is performed by John Segars, Director of Health Plan Operations. Plan oversight of the encounters function is overseen by Diana Michalic.
1.4.2 Network Management Claims/ Encounter Processing Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Utilization Management (Coordinator, Manager, Director);						Debra Enigl, RN is the Vice President of Healthcare Services. Reba Cartee, RN, BSN serves as the Director, Healthcare Services for Utilization Management, and Tammy Webb, PhD, MSN serves as the Director, Health Care Services for Case Management.
1.5.1 Pharmacy Director,	X					The Pharmacy Director is Alfred Romay, PharmD. He is not licensed in South Carolina but indicated during the onsite visit that he holds licenses in multiple states. *Recommendation: The Pharmacy Director should consider obtaining a SC license.*
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Associate Vice President of Quality Improvement is Patricia Zigon. Ms. Zigon is responsible for the Quality Improvement activities in several states. Molina indicated that Wilson Huang, Manager of Quality Interventions, fulfills the *SCDHHS Contract* requirement for a full-time Quality Improvement Manager/Director located in South Carolina. Mr. Huang does not hold any quality certifications as suggested by the *SCDHHS Contract, Section* 2.2. His background is in biological engineering and engineering management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Molina should consider requiring the Quality Manager to have relevant experience in healthcare quality improvement or obtain a certification in quality. *Recommendation: The Quality Manger should consider obtaining a quality certification.*
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Director of Provider Services is Jennifer Marze and the Manager of Provider Services is Heather Eddins.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Lisa Cattani is the Director, Member and Provider Contact Center. Per onsite discussion, Molina has a centralized call center handled by locations in Michigan and Utah. Addie Bors is the Manager, Member Engagement and she is located in SC.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Cheryl Shafer (Internal Medicine) is the Chief Medical Officer and Vice President of Medical Affairs. Additional Medical Directors include: •Dr. Delores Baker, Ob-Gyn •Dr. Nickitas Thomarios, Psychiatrist Molina has an open position for a Medical Director due to the recent departure of Dr. Shrouds.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						All Medical Directors are licensed in South Carolina.
1.10 *Compliance Officer;	X					The Director of Compliance is Niurka Adorno Gonzalez.
1.10.1 Program Integrity Coordinator;	X					Niurka Adorno Gonzalez acts as the Program Integrity Coordinator and works with the corporate Special Investigations Unit (SIU).
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Beverly Hamilton, Director of Government Contracts, serves as the Interagency Liaison. She reports to Nichole Melton-Mitchell, AVP Government Contracts in SC.
1.12 Legal Staff;	X					Molina Healthcare of South Carolina has legal counsel through an administrative services agreement with its parent company Molina Healthcare, Inc (MHI).
1.13 Board Certified Psychiatrist	X					Nikitas Thomarios, D.O. serves as the Behavioral Health Medical Director. Dr. Thomarios is a board-certified psychiatrist licensed in South Carolina.
1.14 Post-payment Review Staff.	X					Post-payment review is conducted through SIU investigations. Molina has two local staff investigators. Additional resources in Florida and California are available, if needed.
2. Operational relationships of MCO staff are clearly delineated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Molina shows that it has the systems in place to process claims, and the information provided states the systems are upgraded to the latest versions routinely. Molina documents it recently tested its QNXT system with the aid of Unisys and Intel, validating their ability to manage 5 million-member lives in each of their state health plans.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Molina follows national industry standards and state companion guides to support HIPAA 5010 Medical (837P), Institutional (837I) and Dental (837D) formats, other proprietary formats, and National Council for Prescription Drug Programs (NCPDP) formats.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					The material provided shows Molina meets the formats and methods specified by HIPAA and SCDHHS. Molina's process documentation demonstrates that it is capable of updating the required eligibility/ enrollment databases and handling 834 transactions. Also, the MCO shows its ability to uniquely identify a distinct Medicaid member across its platforms and to identify and correctly process any potential duplicate records.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					The ISCA documentation includes report examples, employee training data, quality control measures, data flow diagrams, infrastructure details, and performance data that all show claims can be processed according to contract. Molina's documentation demonstrates it has the ability to provide required reports and to meet its contractual obligations.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					According to the information submitted, Molina has processes and procedures in place to address data security. These include VPN use, audit trails, details of all logins, transaction reports, and error logs. Each Molina location requires the use of an employee badge to gain entry to the facility via an electronic card reader. Every Molina employee is issued a photo identification badge that must be worn while in the Molina facility. Visitors are required to sign in when entering the facility. All visitors are escorted within the facility at all times. Visitors must wear an ID badge at all times. Each area is controlled by an HID proximity reader which limits access to restricted areas. Employees are granted access per their job role and responsibilities within the company. Only personnel who work in a particular area or require access to it in the performance of their jobs are allowed access for that area. A report is maintained of all employees allowed or denied access to a particular area and dates and times of access.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						All network servers and routers are kept in a controlled location only accessible via a proximity card reader. Access into this equipment is only authorized to specific Molina network and management staff.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Molina's documentation shows that policies and procedures exist to sufficiently address system and information security as well as access management. Physical and software controls are in place at necessary points. System access is authorized and granted on a business need-to-know basis or via a validated registration process for customers and providers.
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					The MCO has a Disaster Recovery/Business Continuity Plan. Molina reports the following tests were performed in 2017: •In April, a test was performed to verify the QNXT 5.3 application could be recovered in the Texas data center (DC02) to support business functions. The test completed and all objectives were achieved successfully. •In June, a test was performed based on a fire incident scenario. According to the documentation, the exercise addressed the needs to support the health plan during a fire successfully.
I D. Compliance/Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has written policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					Multiple documents such as policies and procedures, the South Carolina Compliance Plan, and a Fraud, Waste and Abuse Plan address Molina's compliance with program integrity requirements.
2. Written policies, training plans, and/or the Compliance Plan includes employee and subcontractor training.	X					
3. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					Policy MHSC COM 05, Compliance Committee Charter, states that Molina has established and maintains a Compliance Committee to monitor, audit, and conduct inquiries and investigations regarding compliance matters. The Compliance Committee is chaired by the Compliance Director and committee members shall not exceed eight members. The Committee meets at least quarterly and a quorum is defined as a simple majority of members present at the meeting. Committee Minutes reflect member participation; however, it is difficult to determine who voting members of the committee are. *Recommendation: Update the minutes to define the voting members of the Compliance Committee and whether they are in attendance or absent.*
4. The MCO has policies and procedures in place that define the processes used to conduct post payment audits and recovery activities for fraud, waste, and abuse activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO has policies and procedures that define how investigations of all reported incidents are conducted.	X					The Molina FWA Plan 2017-2018 explains the Director of Compliance, along with the SIU, has the responsibility and authority to report all investigations resulting in a finding of possible acts of fraud, waste, and abuse by providers or members to SCDHHS. The Plan is detailed and explains investigation and reporting to appropriate authorities.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Numerous policies and procedures address privacy and confidentiality along with uses and disclosures of Protected Health Information (PHI).

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Policy MHSC CR-01, Credentialing Program Policy, addresses the process for credentialing and recredentialing practitioners in to the Molina Healthcare of South Carolina network. The policy is detailed and the credentialing program was developed in accordance with state and federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The credentialing program is reviewed annually and updated, as needed. The following issues were found in Policy MHSC CR-01: •Page 6 states, "Another accepted source listed for the credential as defined in the attached Addendum A (Practitioner Criteria and Primary Source Verification Table);" however, Addendum A is not found in the document. CCME confirmed during onsite discussion that the information found in Addendum A was placed in a table in the document beginning on page eight. •Page 35 also mentions the Practitioner Criteria and Primary Source Verification Table. CCME suggests adding the title to the table on page eight, "Practitioner Criteria and Primary Source Verification Table" or correcting the reference in the document. *Recommendation: Update Policy MHSC CR-01, Credentialing Program Policy, to remove references to Addendum A, Practitioner Criteria and Primary Source Verification Table.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Peer Review & Credentialing Committee (PRC) provides oversight for the provider credentialing program and peer review for certain quality of care concerns. Dr. Delores Baker, Medical Director, chairs the committee with the Chief Medical Officer, Cheryl Shafer serving as back-up Committee Chair. Additional voting members include Medical Director, Dr. Nickitas Thomarios, and five network providers. Voting committee members represent the specialties of OB/GYN, internal medicine, pediatrics, cardiology, and psychiatry. A quorum is met with the presence of three network physician members. Meeting minutes showed active participation by committee members and all meeting minutes CCME reviewed reflected that a quorum was met for all decisions. The 2017 QI Program Description states the name of the credentialing committee as the Professional Review Committee (PRC); however, the Credentialing Program Policy and Committee Charter refer to the committee as the Peer Review & Credentialing Committee (PRC). *Recommendation: Update the QI Program Description to reflect the correct name for the PRC.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files were organized, easy to reference, and for the most part contained appropriate documentation. Any issues are discussed in the respective section.
3.1 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;		X				Onsite discussion confirmed that both the SC Excluded Provider's Report and the Terminated for Cause List are queried during credentialing. Proof of querying the Terminated for Cause List is not in the files. *Quality Improvement Plan: Ensure credentialing files contain proof of query of the Termination for Cause List.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;		X				Molina indicated during onsite discussion it does not pursue hospital admitting arrangements for behavioral health providers that are not MDs; however, admitting arrangements should be addressed for all providers. *Quality Improvement Plan: Ensure hospital admitting arrangements are addressed for all providers during the credentialing process.*
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Ownership Disclosure form.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files are organized, and for the most part contain appropriate documentation. Any issues are discussed in the respective section.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;		X				Onsite discussion confirmed that both the SC Excluded Provider's Report and the Terminated for Cause List are queried during recredentialing. However, proof of querying the Terminated for Cause List is not in the files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure recredentialing files contain proof of query of the Termination for Cause List.
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;		X				Two recredentialing behavioral health files do not address hospital admitting arrangements. Onsite discussion confirmed that Molina does not pursue hospital admitting arrangements for behavioral health providers that are not MDs; however, CCME recommends addressing admitting arrangements for all providers. *Quality Improvement Plan: Ensure hospital admitting arrangements are addressed for all providers during the recredentialing process.*
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					Policy MHSC-CR-05, Ongoing Monitoring and Intervention, defines the process for ongoing monitoring of practitioner grievances and quality issues between credentialing cycles. Molina monitors member grievances regarding practitioner issues, adverse events, and other Potential Quality of Care (PQOC) issues between re-credentialing cycles for all practitioner types. Information obtained during the ongoing monitoring process is included in the practitioner's credential file and is evaluated at the time of recredentialing. Molina provides HEDIS Gaps in Care reports on the Provider Portal where providers can view non-compliant members across various HEDIS measures.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Procedure MHSC QI 500.000, Potential Quality of Care Issues, defines the process for evaluating potential quality of care issues, providing a process for identifying potential quality of care issues, and stratifying the risk levels. Policy MHSC-CR-01, Credentialing Program, addresses ongoing monitoring, which includes investigating practitioner-specific grievances and monitoring practitioner adverse events. Actions include corrective action, suspension, or termination, including notification to authorities and practitioner appeal rights as appropriate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				Policy MHSC CR-02, Assessment of Organizational Providers, defines the credentialing and recredentialing process for organizational providers. The policy does not address the need to query the Termination for Cause List; however, CCME confirmed onsite that the list is queried. The organizational provider credentialing/recredentialing file review showed appropriate documentation except it did not reflect queries of the Termination for Cause List. *Quality Improvement Plan: Update Policy MHSC CR-02, Assessment of Organizational Providers, to reflect the need to query the Termination for Cause List. Ensure credentialing/recredentialing files contain proof of query of the Termination for Cause List.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				Policy MHSC CR_01, Credentialing Program Policy, defines the process for ongoing monitoring of sanctions between re-credentialing cycles for all practitioner types. The policy defines the various screenings but does not specify if the Termination for Cause List is queried. *Quality Improvement Plan: Update Policy CR_01, Credentialing Program Policy, to include the Termination for Cause List as queried for ongoing monitoring.*
II B. Adequacy of the Provider Network						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy MHSC-PC-011, Availability of Health Care, defines the established availability standards for primary care which includes family/general practice, pediatrics, internal medicine, and federally qualified health centers/rural health centers. The availability standards require primary care as 90% of members within 30 miles/45 minutes. GeoAccess reports were received showing the mileage standard used as 1 PCP within 30 miles. CCME confirmed during onsite discussion that the plan runs GeoAccess reports using the standards for minutes when a provider category does not meet the miles standard.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy MHSC-PC-011, Availability of Health Care, defines the availability standards for specialty care and behavioral health practitioners that complies with contract requirements. Results of the Practitioner Availability and Network Adequacy Analysis for 2016 showed PCP and specialists, including behavioral health, met all goals established for the geographic distribution standards. CCME received GeoAccess reports showing the mileage standard used as 1 provider within 50 miles.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy MHSC-PC-011, Availability of Health Care, states Molina assesses against established standards to measure practitioner availability on a quarterly basis, and, when deficiencies are identified, Molina implements corrective actions. This is accomplished through Geo Access reporting. Annually the Provider Contracting Department develops a written availability evaluation and plan that outlines Molina's strategy for maintaining an adequate network of practitioners.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Molina assesses the cultural, ethnic, racial, and linguistic needs and preferences of its members on an ongoing basis. Information gathered during quarterly monitoring and annual network assessment is used to identify and eliminate cultural and/or linguistic barriers to care through the implementation of programs and interventions. Molina utilizes interpreter services vendors to provide American Sign Language (ASL) and all telephonic interpreter services. Educational opportunities are offered in cultural competency concepts for providers on a regular basis. Provider training is conducted concurrent with and integrated into provider orientation with annual reinforcement training. Additional training reinforcement is provided through continuing medical education (CME) monographs developed by the health plan and periodically accompanying provider communications. Cultural Notes, a monthly newsletter publication, is emailed to interested providers highlighting important cultural customs relevant to plan members.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.		X				Provider Directories are available on the Internet, by paper copy and by calling the Member Services Department. Members may also request additional information regarding practitioner qualifications to include practitioner education and training. Policy MHSC CR-01, Credentialing Program Policy, states that at least once per month the Credentialing Department extracts credentialing data from the credentialing database into a spreadsheet and forwards to the Provider Configuration Department. The data are then loaded into a contracting database and subsequently uploaded directly into the on-line Provider Directory. This process verifies the listings in the practitioner directories are consistent with credentialing data. The policy states, “At least once every quarter, the Corporate Credentialing Department pulls a query from the credentialing database and randomly selects a sample of practitioners. The credentialing employee looks up each on the MHSC web-based Practitioner Directory and validates that the data exactly matches the credentialing data in the credentialing database. A report is created in a spreadsheet format that indicates if all the data matched or if there were any discrepancies. If any

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discrepancies are discovered, the errors will immediately be corrected. If a trend of errors is identified in this process, a root cause analysis will be conducted to prevent similar errors from occurring in the future." CCME's onsite discussion confirmed this information no longer applies because this process is now completed by the Quality Improvement Department. *Quality Improvement Plan: Update or remove language in Policy MHSC CR-01, Credentialing Program Policy, that discusses the Corporate Credentialing Department performing quarterly audits of practitioner information against information in the Practitioner Directory.*
3.Practitioner Accessibility						
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy and Procedure MHSC-PS-005, Provider Availability Standards, define the availability performance standards for primary care, specialists and behavioral health practitioners that comply with contract guidelines. Molina annually performs availability and after-hours telephonic surveys of its contracted providers to verify compliance. The Accessibility of Services Report conducted May 2017 measured access to primary care, specialty care, and behavioral healthcare. Compliance and performance rates are evaluated against standards and goals. The assessment included a provider appointment and after-hours survey, analysis of access-specific complaints and appeals, and analysis

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of applicable CAHPS 5.0 questions. Results showed low overall scores for PCPs for appointments (routine 74% and urgent 71%), and only 63% of after-hours met the 24/7 coverage standard. Behavioral health providers appointment access scores were low as well (non-life threatening 70%, urgent 70%, routine 75%) and 66% of after-hours met the 24/7 coverage standard. None of the specialties (psychiatry, psychology, licensed social worker, licensed marriage and family therapy, or licensed professional counselor) met the performance threshold for appointment or after-hours. The Accessibility of Services Report did not reflect actions taken to address non-compliant providers. CCME's onsite discussion revealed the Provider Services Department received this report and implemented actions for non-compliant providers, educated providers through telephonic outreach and annual fax blasts, and followed-up with noncompliant providers. *Recommendation: Follow-up with providers who failed the Accessibility of Services Study, consider remeasuring those providers, and document any implemented actions addressing non-compliance.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					The results of the Telephonic Provider Access Study conducted by CCME reflect calls were answered successfully 49% of the time (115 out of 237) when omitting 50 calls answered by personal or general voicemail messaging services. When compared to last year's results of 44%, this year has an increase in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						successful calls but the increase is not statistically significant. *Recommendation: Implement processes to improve overall member access to providers.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy and Procedure MHSC-PS-010, Provider and Practitioner Education, establishes a process for the initial and ongoing education and training of providers and practitioners. All newly contracted providers receive timely training and materials conducted by Provider Services Department staff. Training includes provider online resources, Provider Manual highlights, web portal, access to care standards, provider billing and claims submission, appeal/grievances processes, Fraud, Waste and Abuse, HIPAA requirements, etc.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Providers receive ongoing training information during monthly/quarterly provider site visits, as needed, and/or upon request. Periodic communications for educational purposes includes, but is not limited to, face-to-face presentations, facsimiles, e-communications, mailing provider newsletters, webinars, and the provider website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Molina uses consistent processes in the development and adoption of age-specific Preventive Health Guidelines (PHGs) to assist practitioners and members with making decisions about appropriate healthcare for prevention and early detection of illness and disease as defined in Policy QI-900.000, Preventive Health Guidelines. The PHGs are reviewed and updated at least every two years by the Quality Improvement Committee.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.		X				The adopted PHGs are distributed to appropriate practitioners, facilities, delegates and members. The guidelines are disseminated to physicians by provider newsletters, fax blasts, Provider Relations Representative site visits, the website, and written material upon request. The practice guidelines are also mentioned in the Provider Manual. The following issues exist within the preventive health guidelines: •When the Children and Adolescents link is clicked, it navigates the user to a page with additional links for Children up to 24 Months, Children 2-19 Years, and Child/Adolescent Immunization Schedules. The links for Children up to 24 Months and Children 2-19 Years are not accessible because membership is required to access the information. • Upon clicking the Adults guidelines link, the user is taken to a page with additional links for Adults 20-64, Adult 65 and older, and Adult Immunization Schedule.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The links for Adults 20-64 and Adult 65 and older state the guidelines were retired in October 2017. • The prenatal care guideline was retired in July 2017. *Quality Improvement Plan: Verify the preventive health guidelines for Children up to 24 Months and Children 2-19 Years are accessible and update the retired guidelines.*
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.7 Behavioral Health Services.	X					A few behavioral health guidelines were received in the desk materials and listed on the website, but CCME did not observe a guideline addressing preventive behavioral health specifically. *Recommendation: Consider adopting a behavioral health preventive guideline.*
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy MHSC QI 900.1, Clinical Practice Guidelines, states Molina adopts clinical practice guidelines that are reviewed at least every two years by the Quality Improvement Committee.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.		X				The practice guidelines are listed on the Molina website and mentioned in the Provider Manual. Printed copies of all guidelines are available upon request. The following issues were identified in reviewing the Clinical Practice Guidelines: •Differences exist between what is listed on the website versus information CCME received in the desk materials; i.e. the website shows Chronic Kidney Disease, Detox and substance abuse, and Opioid

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Management; these were not addressed in the desk materials. •At the time of the review, the following CPGs received in the desk materials require the user to be a member to view the guideline: Depression, Heart Failure, and Obesity. *Quality Improvement Plan: Verify the clinical practice guidelines listed on the website are the same guidelines referenced in Molina materials and validate links to guidelines take the user to the specific adopted guideline.*
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Procedure MHSC-HCS-CM-081 PROC, Continuity of Care and Coordination, defines the process for verifying all members receive COC for medical, behavioral, and pharmacy benefits with their existing services per federal or state guidelines.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Molina annually reviews PCPs' member medical records for appropriate communication, coordination, and continuity of care among providers, appropriate documentation of patient demographic and clinical information that supports effective practices of care, and preventive health. Procedure MHSC QI 120.000, Standards of Medical Record Documentation, defines the minimum standards for medical record documentation and information is also listed in the Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Molina conducted a medical record review audit in 2017 with a sample size of 145 medical records consisting of 29 unique in-network providers throughout the state of South Carolina. Of 145 medical records requested, Molina received and audited 120 records which represented a 13.9% decrease from the 2016 audit. Results showed initially 21 provider groups received a score of 90% and above with 2 provider groups failing. However, the two groups passed upon the re-audit which reflected in total that 23 provider groups passed, and 6 provider groups were not scored because the records could not be received. Opportunities for improvement and planned interventions were addressed in the report.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Procedure MHSC-ME-04, Member Bill of Rights & Responsibilities, defines member rights and responsibilities and indicates members are informed of their rights in annual member newsletters, on the Molina website, and in the Member Handbook.
2. Member rights include, but are not limited to, the right:	X					Member rights are documented in the Member Handbook, Provider Manual, and the Molina website.
2.1 To be treated with respect and with due consideration for his or her dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information including:		X				Policy MHSC-ME-01, New Medicaid Member Outreach and Education, indicates Molina sends educational materials within 14 calendar days from the date the eligibility file is received. ID cards are sent within 14 calendar days from the date the eligibility file is received or the date a PCP is selected, whichever is later. Molina's Print and Fulfillment Department mails the Welcome Packet and ID cards. Onsite discussion confirmed the Welcome Packet includes a welcome letter, instructions for accessing and requesting the Member Handbook and Provider Directory, and the Notice of Privacy Practices.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						As required by the *SCDHHS Contract, Section 3.14.2*, Molina maintains a Change Control Record for the Member Handbook on its website.
1.1 Full disclosure of benefits and services included and excluded in their coverage;						The Member Handbook and Provider Manual define benefits covered by Molina along with coverage limitations. Issues noted in the benefits information include: •Page 31 of the Member Handbook indicates hysterectomies, sterilizations, and abortions are "Covered when they are non-elective and medically necessary." However, sterilizations are generally elective, and abortions under specific circumstances are elective, coverable services. •Page 35 of the Member Handbook and page 22 of the Provider Manual reference a 4-prescription limit per month; however, the limit of 4 prescriptions per month was eliminated July 1, 2017. Refer to *SCDHHS Medicaid Bulletin MB# 17-014*. •Page 37 of the Member Handbook addresses Rehabilitative Services for Children; however, there is no indication the benefit applies to non-hospital-based services. Refer to the *SCDHHS Contract, Section 4.2.23*. •The Provider Manual does not include information regarding coverage of chiropractic services. •Page 22 of the Provider Manual indicates adult well visits are covered every 2 years. Onsite discussion confirmed this is incorrect and there is no limitation on the frequency of adult well visits. *Quality Improvement Plan: Correct the benefit information specified above.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						The Member Handbook does not include information stating female members may access a women's health specialist for routine and preventive health services in addition to the member's PCP. This information is included on the Molina website. Refer to the *SCDHHS Contract, Section 6.1.6.* *Quality Improvement Plan: Update the Member Handbook to include information that female members may receive women's routine and preventive care from a women's health specialist in addition to services by their PCP.*
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						Page 41 of the Member Handbook addresses the availability of second opinions and instructs members that second opinions may be obtained by another Molina provider or an out-of-network provider at no cost. Onsite discussion confirmed prior authorization is required for a member to obtain a second opinion from an out-of-network provider; however, this is not indicated in the Member Handbook information regarding second opinions. Members are instructed to call Member Services to learn how to get a second opinion. *Recommendation: Revise the Member Handbook to indicate prior approval is needed for a second opinion from an out of network provider.*
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						Co-payments are required for inpatient hospital services, non-emergency outpatient hospital services, pharmacy, and dental services. Information on co-payments is found throughout the Member Handbook. The Provider Manual defines copayment requirements but does not include the $3.40 co-payment for dental services. *Quality Improvement Plan: Revise the Provider Manual to include the co-payment requirement of $3.40 for dental services.*
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						The Member Handbook defines an emergency and provides information on when to seek emergency versus urgent care. Members are informed that the Nurse Advice Line is available 24-hours a day to assist members with understanding the care they need and how to obtain care.
1.7 Procedures for post-stabilization care services;						Brief information on post-stabilization services is provided in the Member Handbook.
1.8 Policies and procedures for accessing specialty/referral care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						Procedure MHSC-ME-07, Changes in Benefits, states members are informed of upcoming changes in benefits or services by mail at least 30 days prior to the effective date of the change. The Member Handbook explains that members are notified of any changes in services or benefits as they occur. Molina makes a good-faith effort to notify members by mail within 15 days after receiving notification of a provider's termination.
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.12 Procedures for disenrolling from the MCO;						Procedures for members to request disenrollment and an explanation of plan-initiated disenrollment are included in the Member Handbook. The Member Handbook explains that Molina may not request disenrollment because of an adverse change in health status, use of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from special needs.
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						Use of the Provider Directory is explained in the Member Handbook. Members are informed they can contact Member Services to request a printed copy of the Provider Directory or view the Provider Directory on the Molina website. The online, searchable Provider Directory allows members to locate a provider by city/zip code, county, street address, distance, provider type, specialty, name, language, gender, medical group, and hospital affiliation.
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						The Member Handbook confirms free language assistance is provided, including sign language interpreters, alternate format written materials, language interpreters, written translation of member materials, and TTY/TDD services.
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Handbook includes the Member Services TTY/TDD number, telephone and fax numbers, and mailing address as well as the phone numbers for the Nurse Advice Line. Toll free numbers for SCDHHS, the Social Security Administration, and SC Healthy Connections Choices are also included. Onsite discussion confirmed members can e-mail Member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Services through the Member Portal on the Molina website.
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						An overview of EPSDT services is provided in the Member Handbook. Members are informed EPSDT services are covered at no cost from birth through the month of the member's 21st birthday. The recommended schedule for well-care checkups is found on Molina's website. A table in the Member Handbook (pages 43-44) includes recommended services for age ranges, but the periodicity table is not included in the Member Handbook. *Recommendation: Include the periodicity table for well-care services and screenings in the Member Handbook.*
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can receive assistance with executing an advance directive;						A detailed explanation of Advance Directives, including the differences between Durable Powers of Attorney, Living Wills, Guardian Appointments, and Declarations for Mental Health Treatment, are found in the Member Handbook. The information provides instructions about how to formulate, implement, and change an Advance Directive.
1.22 Information on how to report suspected fraud or abuse;						The Member Handbook includes information on Fraud, Waste, and Abuse (FWA). Members may report

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						suspected or actual FWA telephonically via the Molina Healthcare Alert Line or online at MolinaHealthcare.AlertLine.com. Reports may also be made directly to the SCDHHS Medicaid Fraud and Abuse Hotline or to the SC Attorney General Medicaid Fraud Unit. Contact information for the various reporting methods is included, and members can report suspected FWA anonymously.
1.23 Additional information as required by the contract and by federal regulation;						
1.24 The MCO notifies each member, at least once per year, of their right to request a Member Handbook or Provider Directory.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Procedure MHSC-ME-07, Changes in Benefits, states members are informed of upcoming changes in benefits or services by mail at least 30 days prior to the effective date of the change. Molina makes a good-faith effort to notify members by mail within 15 days after receipt of notification of a provider's termination. Onsite discussion revealed the online provider directory is updated every 7 days.
3. Member program education materials are written in a clear and understandable manner and meet contract requirements.	X					Procedure MHSC-COMM-03, Member Collateral Materials, confirms member materials are written at no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. Materials are written using a minimum 12-point font. When 5% or more of the resident population of a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						county is non-English speaking and speaks a specific language, materials are made available in the respective language.
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					Member Services Call Center functions are conducted by staff in Texas, Michigan, and California. Updates in member benefits, services, policies, etc. are communicated to staff in these states via the Government Contracts Department or Compliance Department. Call center leaders ensure the new information is disseminated to call center staff. Searchable databases are maintained for call center staff to retrieve information specific to callers' needs readily so that accurate, current information is relayed. The toll-free Member Services telephone number routes calls to Interactive Voice Response (IVR) menus so that callers are directed to appropriate staff. After hours, the IVR provides instructions to call 911 for an emergency, normal operating hours, and provides callers with the option to leave confidential voicemail for Member Services or Care Management staff. Callers also have the option to transfer to the 24-hour Nurse Advice Line. Policy MHSC-MS-01, Contact Center Performance, defines performance standards which follow SCDHHS Contract requirements for speed of answer, percentage of calls receiving a busy signal, and abandonment rate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					Policy MHSC-ME-05 and Procedure MHSC-ME-05 (Medicaid Member Disenrollment) define requirements and processes for member disenrollment. When notified by SCDHHS of a member's request to disenroll, Molina's Member Appeal and Grievance staff investigate the member's concerns and attempt to resolve those concerns prior to disenrollment.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Policy MHSC-ME-01, New Medicaid Member Outreach and Education, confirms members who do not have a PCP assigned at enrollment will be auto-assigned to a PCP based on approved algorithms. Call center staff are available to assist members in selecting a PCP. Members may also select or change a PCP via the online Member Portal or the Molina HealthinHand smart phone application.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					Molina's website contains wellness checkup schedules and recommended screenings for members of all ages. The website also describes the disease management programs available to members for asthma, diabetes, COPD, and heart healthy living. Mailings and postcards are sent to members to encourage members to participate in recommended screenings and preventive care. Incentives are offered for members to participate in the recommended services.
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care.	X					Procedure MHSC-HCS-CM-002, High Risk Pregnancy-Screening and Triage to Disease Management/Case Management, indicates various ways pregnant members are identified. Trained staff contact identified pregnant members by telephone to screen for high risk pregnancy conditions and further assessment/evaluation is conducted when a member is identified as a possible candidate for High Risk Obstetrical (HROB) case management (CM). •If criteria are met for HROB CM, the Case Manager opens a case, develops a care plan, and schedules regular follow-up calls, education, and mailings appropriate for the member's risk status. •For members who do not meet criteria for HROB CM, Molina's Motherhood Matters® Pregnancy Program supplies education and services needed for a healthy pregnancy, including telephonic counseling, educational materials and resources, coordination with social services, and care management services by a nurse.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Procedure MHSC-HCS-UM-331, Continuity of Care, confirms Molina allows pregnant members continued access to out-of-network, terminating, or terminated practitioners through the member's postpartum period.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.		X				Onsite discussion revealed members eligible for EPSDT services are monitored using HEDIS and claims data. Molina staff work with providers to contact members and assist in scheduling appointments to participate in recommended EPSDT services. In addition, members are sent reminders by mail to participate in recommended services. Member Services Call Center staff receive Care Gap alerts when engaging with members by phone to prompt them to encourage members to receive the recommended services. As confirmed during onsite discussion, Molina does not have a policy defining processes and requirements for the EPSDT Program. The *SCDHHS Contract, Section 4.2.10.1*, requires written policies and procedures for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible Medicaid Managed Care Program children and young adults. *Quality Improvement Plan: Develop a policy/procedure or EPSDT Program Description to define the EPSDT Program and Molina's processes to monitor and encourage member participation in recommended EPSDT services.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					The Molina website provides a variety of information regarding wellness and prevention topics including exercise programs, well checkups, senior health, caring for health conditions, women's wellness, tips for staying healthy, and Clear and Easy booklets. Throughout the state of South Carolina, Molina hosts community events for both members and non-members. By sometimes co-branding with other organizations, awareness of and attendance at these events is enhanced. Various methods are used to advertise the community events, including flyers, billboards, notices placed in churches and provider offices, and email. Health screenings are offered during some of the events, and attendance is documented for all events.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					Molina contracts with SPH Analytics, a certified CAHPS survey vendor to conduct Adult and Child surveys.
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					The sample sizes for the survey were adequate and met the NCQA minimum sample size and number of valid surveys, but the response rates were below the NCQA target of 40% (26.9% for adults and 24.7% for children). *Recommendation: Continue working with SPH Analytics to increase response rates for Adult and Child surveys. Possible interventions for increasing*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						response rates include adding a reminder to call center scripts, maximizing the oversampling, and allowing a longer timeline for additional reminders and to conduct phone call surveys. CCME encourages Molina to decide upon and document an internal goal to increase response rates (such as a 3% increase each year).
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					SPH Analytics summarizes and details all results from both surveys. Molina's Quality Improvement Evaluation displays analysis of data and action steps to achieve higher scores for member satisfaction.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					The analysis and implementation of interventions to improve member satisfaction are conducted by the Quality Improvement Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO reports the results of the member satisfaction survey to providers.	X					Results of the CAHPS Surveys were offered to providers in the Fall 2016 Provider Newsletter.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					The CAHPS Outcome Report for 2017 was presented to the Quality Improvement Committee on 11/2/17.
III F. Grievances						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy and Procedure MHSC MS-18, Member Grievances, defines Molina's processes for handling member grievances by the Member and Provider Contact Center. Policy MHSC-MIRR-001, Grievance Disposition Process, and its associated procedure define Member Inquiry Research & Resolution (MIRR) Department processes for receiving, investigating, and resolving verbal and written member grievances.
1.1 Definition of a grievance and who may file a grievance;		X				Grievance terminology is appropriately defined across all documents reviewed, including Policy and Procedure MHSC MS-18, Member Grievances, Policy and Procedure MHSC-MIRR-001, Grievance Disposition Process, the Member Handbook, the Provider Manual, and Molina's website. Issues regarding who may file a grievance include: •Policy MHSC-MIRR-001, Grievance Disposition Process, states a provider or member's authorized representative acting on behalf of the member with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the member's written consent may file a grievance. The corresponding procedure document states only the member or member's authorized representative may file a grievance. The procedure does not indicate a provider can file a grievance on behalf of a member or that written consent is required. •Page 52 of the Member Handbook indicates a person the member chooses can file a grievance but does not indicate written consent is required. *Quality Improvement Plan: Revise Procedure MHSC-MIRR-001, Grievance Disposition Process, to include verbiage that a provider may file a grievance on a member's behalf with written consent. Update the Member Handbook to state written consent is required for another person to file a grievance on the member's behalf.*
1.2 The procedure for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;		X				Molina follows a 90 calendar-day timeframe for grievance resolution with a 14-day extension available under certain circumstances; however, Policy and Procedure MHSC MS-18, Member Grievances, states grievances are investigated and responded to within 5 business days. This sounds as if the final resolution is issued to the grievant within 5 business days and could lead to confusion for staff. Page 52 of the Member Handbook and page 118 of the Provider Manual indicate that if an extension of the grievance resolution timeframe is requested, Molina must be able to explain to SCDHHS how the delay is in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the member's interest. According to the *SCDHHS Contract, Section 9.1.6.1.4,* Molina must be able to explain the necessity of an extension only when the extension is requested by Molina, and not when requested by the member/authorized representative. *Quality Improvement Plan: Revise Policy and Procedure MHSC MS-18, Member Grievances, to reflect the 90-day resolution timeframe for grievances.* *Recommendation: Update the Member Handbook and Provider Manual to reflect that Molina must be able to explain the necessity of a grievance resolution timeframe extension only for extensions requested by Molina.*
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					Policy MHSC-MIRR-001, Grievance Disposition Process, defines individuals who issue grievance decisions for grievances regarding the denial of an expedited resolution of an appeal or involves clinical issues. Procedure MHSC-MIRR-001, Grievance Disposition Process, defines the process for referring potential quality of care (PQOC) grievances to the Quality Improvement (QI) Department for investigation and resolution. The procedure also defines who reviews and resolves PQOC grievances.
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Molina logs grievance information monthly and submits a quarterly report to SCDHHS. Procedure MHSC-MIRR-001, Grievance Disposition Process, confirms grievance documentation and relevant correspondence are retained for 10 years in a non-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						editable format and provided upon request to regulatory and oversight agencies.
2. The MCO applies the grievance policy and procedure as formulated.	X					All reviewed grievance files reflected timely acknowledgement and resolution. Three files referred to other departments for investigation did not contain documentation of the investigation or findings. *Recommendation: Ensure grievance files reflect investigations and findings when reviewed by staff in other Molina departments.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Quarterly analyses of grievances are conducted and presented to the Quality Improvement Committee to identify potential issues and opportunities. QIC minutes confirm detailed reporting and robust discussion of grievance data and analyses.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					Molina provided the 2017 Medicaid Quality Improvement Program Description as evidence the Plan provides the structure and key processes for ongoing improvements of care and services Molina provides to members and providers. This program description was reviewed and approved by the Quality Improvement Committee and Molina's Board of Directors.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					Per the QI Program Description, Molina monitors adherence to clinical practice and preventive guidelines via an annual random sample medical record review audit and quarterly claims data analysis of specific HEDIS outcome and process measures.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Molina's Work Plan is comprehensive and includes all required elements.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Improvement Committee (QIC) is responsible for the implementation and ongoing monitoring of the QI program. The QIC reviews data from QI activities to verify that performance meets standards and makes recommendations for improvements.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC is chaired by the Chief Medical Officer, Dr. Shafer, and membership includes senior leadership, department directors and seven network providers.
3. The QI Committee meets at regular quarterly intervals.	X					QIC meets at least quarterly and a quorum of 60% of the members with no less than three network providers is needed to enact or implement decisions. In 2017 this committee met four times.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					Molina uses Inovalon, a certified software, for HEDIS Measure calculation. The comparison from the previous to the current year reveal a strong increase in Asthma Medication Ratio and Metabolic Monitoring for Children and Adolescents on Antipsychotics. The measures that decreased are the Statin Therapy for Patients with Cardiovascular Disease and Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia. Details of the validation of the performance measures may be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two projects were validated using the EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012. They included Well Care (Clinical) and Improving Claims Accuracy and Provider Satisfaction.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				The Well Care (Clinical) PIP scored within the "High Confidence" range and the Claims Accuracy and Provider Satisfaction PIP scored within the "Confidence" range. Details of the validation of the PIPs may be found in the *CCME EQR Validation Worksheets, Attachment 3.* *Quality Improvement Plan: Correct the errors Identified in the Performance Improvement Project documents.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Although it was not validated this year, CCME conducted a preliminary review of the Breast Cancer Screening PIP. CCME has concerns that the longevity of this PIP is still showing very little positive effect on the breast cancer screening rate. The rates have increased, but the actual effect from the mobile mammogram appears to be minimal, as shown by the graph on the last page of the report that shows most counties have less than 5% of members who were compliant. For the Interventions Table, the barriers are listed on the right and the interventions to address the barriers should be in the left column. The first part of the Table documents this correctly; the latter part of the Table shows barriers but not how the interventions address those barriers. For example, on page 84 the barrier is Provider Engagement, and the intervention is listed as "Hope Health- 29 eligible members that have not received a mammography." This is not actually an intervention to address Provider Engagement, more information is needed in the intervention column. There is a barrier that says "Members Are Unable to Attend Mobile Mammogram Events due to Child Care Needs, Difficulty Taking Time from their Job or Additional Personal Constraints," and the intervention is a gift card. It does not readily appear that a gift card will help with child care needs and difficulty with taking time from a job for health care. *Recommendation: The barriers and the interventions for the Breast Cancer Screening PIP must align. Implement new, member-directed interventions to*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						address child care needs and other constraints, and correct the errors in the Interventions Table. Discontinue ineffective interventions and implement new interventions that address all barriers.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Policy No. MHSC QI 122.000, Provider Communication Regarding the Quality Improvement Program, discusses the mechanisms Molina uses to communicate with network providers regarding the QI Program. This includes peer to peer discussions and routine practice visits and meetings regarding provider performance data. Molina also maintains a Provider Portal where provider groups can access HEDIS results and member gaps in care.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Molina evaluated the effectiveness of the QI program annually. CCME received the Quality Improvement Program 2016 Annual Evaluation with the desk materials. The 2017 Annual Evaluation is a draft.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					The annual evaluation is presented to the QIC and the Board of Directors for review and approval.

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. UTILIZATION MANAGEMENT						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Healthcare Services (HCS) Medicaid Program Description dated 12/9/17 outlines and describes the Utilization Management (UM) Program. Policies and procedures are established to support the implementation and operation of the program.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					The HCS Medicaid Program Description describes the UM program structure and methodology used to evaluate medical necessity.
1.2 lines of responsibility and accountability;	X					The lines of accountability are listed in Section 3 of the HCS Medicaid Program Description. It describes responsibilities for the executive leadership, Board of Directors, and various committees. Levels of decision-making are outlined in Procedure MHSC HCS UM 364, Appropriate Professionals Making UM Decisions.
1.3 guidelines / standards to be used in making utilization management decisions;	X					Guidelines/standards used in making UM decisions are described in the HCS Medicaid Program Description and detailed in Procedure MHSC HCS UM 365, Clinical Criteria for Utilization Management Decision Making.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				Requirements for timeliness of UM decisions are described in Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification. Procedure MHSC-PHARM-02, Pharmacy Prior Authorization Requests, notes coverage determinations will be made within 14 calendar days; however, page 45 of the Member Handbook and page 41 of the Provider Manual indicate pharmacy determinations are made in 24 hours. Onsite discussion revealed Molina changed the pharmacy determination timeframe from 24 hours to 14 days based on instructions received from SCDHHS. Evidence of this instruction was provided to CCME. *Quality Improvement Plan: Revise the Provider Manual and Member Handbook to reflect pharmacy authorization determinations are made within 14 calendar days.*
1.5 consideration of new technology;	X					Consideration of new technology is noted in the HCS Medicaid Program Description. The process for assessing appropriate use of new technologies, procedures, drugs, equipment and devices are addressed in Policy MHSC-HCS-UM-323, Authorization of New Medical Technologies (Experimental and Investigational Services).
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Molina Healthcare does not provide additional compensation or incentive to providers or staff for denial of coverage or services as described in the 2017 HCS Medicaid Program Description and noted in the both the Provider Manual and Member Handbook.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 the mechanism to provide for a preferred provider program.	X					Criteria for the Preferred Provider Program is described under Section 32: Provider Profiling Program in the HCS Medicaid Program Description. Molina has developed a Preferred Provider Program; however, providers are not informed of the availability of this program consistently. During the onsite visit Molina provided a document titled "MHSC Preferred Provider Program" which outlines the Preferred Provider Program. Onsite discussion revealed no providers were added to the program since the previous EQR due to providers not meeting both the quality and HEDIS criteria for inclusion in the program. During onsite discussion, Molina stated some providers with infrequent requests for prior authorization may not be interested in participating. Presently the health plan does not have any providers in the Preferred Provider Program. *Recommendation: Explore opportunities to notify providers about the Preferred Provider Program, such as in the Provider Manual and during provider meetings.*
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Oversight of UM activities is conducted by the Chief Medical Officer (CMO), Cheryl Shafer, MD. The HCS Medicaid Program Description includes the CMO's responsibilities. The CMO chairs the QIC as noted in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						meeting minutes and ensures quality outcomes of the HCS Department as noted by approval of work plans. The Medical Director/Associate Medical Director reports to the CMO. The HCS Medicaid Program Description includes the Medical Director and Associate Medical Director's responsibilities. The Behavioral Health (BH) Associate Medical Director is involved in the implementation of the BH aspects of the UM program. Nikitas Thomarios, MD is the BH Medical Director, is a voting member of the Health Care Services Committee (HCSC), and participates in meetings where BH policies are discussed and approved as reflected in HCS meeting minutes.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The HCS Medicaid Program Description notes the UM program is reviewed, evaluated, and updated annually under the direction of the HCSC and Quality Improvement Committee (QIC). The HCS committee approves all medical necessity criteria including clinical criteria for behavioral health. The HCS work plan lists goals for activities and initiatives implemented in 2016 and provides a means to evaluate results to determine future plans. It was reviewed and evaluated on March 27, 2017 and approved by the CMO and the HCSC Chairman.
V B. Medical Necessity Determinations						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Procedure MHSC-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making, lists how utilization management standards and criteria are used for determining medical necessity. The approved and acceptable resources for clinical criteria are listed in a hierarchy for use.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Sampled approved UM files reflect consistent decision making using criteria and relevant medical information as described in Procedure MHSC-HCS-UM-365, Clinical Criteria for Utilization Management Decision Making.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Procedure MHSC-HCS-UM-358, Abortions Hysterectomies, Sterilizations, and supported by the associated policy. The criteria for use are communicated in the Member Handbook and the Provider Manual. The applicable forms for abortion, sterilization, and hysterectomy are correctly noted in the Provider Manual and are consistent with the SCDHHS requirements.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Molina allows for unique patient decisions as noted in Procedure MHSC-HCS-UM-363, Continuity of Use of Clinical Utilization Criteria, which describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.		X				Policy MHSC-HCS-UM-376, Molina Way Inter-rater Reliability (IRR) Documentation Guidelines, states Molina conducts annual IRRs to evaluate comprehension and consistent application of approved criteria and guidelines. Procedure MHSC-HCS-UM-376, Molina Way Inter-rater Reliability (IRR) Documentation Guidelines, states an annual assessment is conducted using the 8/30 audit methodology. The procedure states 30 files are randomly selected for each HCS functional area (prior authorization nurses, concurrent review nurses, medical directors, pharmacists, etc.) making medical necessity determinations. Policy and Procedure MHSC-PHARM-09, Consistency in Application of Medical Necessity Criteria for Pharmacy Services Staff, defines pharmacy staff involved in the IRR process and defines how the IRR is conducted. Onsite discussion confirmed 30 sample files are reviewed for each pharmacy staff member and Medical Director. For other HCS staff, 30 files per staff member are not reviewed—the sample of 30 files is pulled from the functional areas as a whole. Policy and associated Procedure MHSC-HCS-UM-361, Quality Assessment (QA) Process, define processes for monthly auditing of HCS staff. *Quality Improvement Plan: Ensure UM criteria are consistently applied across all reviewers. Revise HCS IRR processes so that all individual reviewers are*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						assessed using the NCQA "8/30 methodology" for file sampling.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions are noted on the Preferred Drug List (PDL) and described in the HCS Program Description and in the Pharmacy Prior Authorization Requests policy and procedure documents. Additionally, pharmacy benefit information is noted in the Member Handbook and Provider Manual. The PDL is posted on both member and provider areas of Molina's website, and indicates which over-the-counter (OTC) medications are covered with a prescription. The PDL is mentioned in the Provider Manual, page 35, but there is no direction about where the PDL is located or how to access it. The Member Handbook includes a reference to the PDL, but the process a member must follow to obtain OTC medications is not explained. The Pharmacy and Therapeutics (P&T) Committee membership includes physicians and pharmacists who have oversight of all pharmacy operations. One function of the P&T Committee is managing the PDL. *Recommendations: Revise the Provider Manual to reference where providers can locate the PDL.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Update the Member Handbook to describe requirements for coverage of OTC medications.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Molina has a process in place for making exceptions to the closed formulary based on medical necessity. Procedure MHSC-PHARM-02, Pharmacy Prior Authorization Requests, and the Pharmacy Program Description describe the process to provide members with a five-day supply of medication in emergency situations while a prior authorization is pending. Additionally, Procedure MHSC-PHARM-03, Pharmacy Lock-in Program, includes the requirement that members in the lock-in program can receive a five-day supply from a pharmacy other than their designated lock-in pharmacy; this information is not communicated in the Provider Manual or Member Handbook. When a member's medical circumstances require specialty pharmacy medications with more immediate access than is available from the Preferred Specialty Pharmacy, Molina allows an initial supply of the medication to be provided at a local pharmacy, as described in the Pharmacy Program Description. This allowance is not communicated in the Provider Manual or Member Handbook. *Recommendation: In the Provider Manual and Member Handbook, include information about the provision of a 5-day emergency supply of medication and about obtaining an initial supply of specialty*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medication from a local pharmacy in clinically urgent situations.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy MHSC-HCS-UM-384, Emergency & Post Stabilization Services, does not address 2 of the requirements for Emergency Services as noted in the *SCDHHS Contract, Section 4.2.11.1.6 and 4.2.11.1.7* as well as in *Federal Regulation § 438.114 (c) (ii) (A) and Federal Regulation § 438.114 (d) (1) (ii)*. The missing items include: •The MCO may not refuse to cover emergency services based on the ER provider, hospital, or fiscal agent not notifying the member's PCP, CONTRACTOR or applicable state entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. •The MCO may not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The policy addresses all required Post Stabilization services listed in *SCDHHS Contract, Section 4.2.11.2* and the Provider Manual describes coverage requirements for Post Stabilization Services. Procedure MHSC-HCS-UM-384, Post Stabilization Review - Emergent Care Visits, describes the workflow for staff receiving requests from hospitals during and after business hours. The headings for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						section A and section B do not clearly define the types of requests addressed by those sections. Discussion during the onsite visit revealed these sections address processes followed when Molina is notified of an admission. *Recommendation: Update Policy MHSC-HCS-UM-384, Post Stabilization Review - Emergent Care Visits to include the two missing requirements specified. Revise the headings for sections A and B in Procedure MHSC-HCS-UM-384, Post Stabilization Review Emergent Care Visits, to indicate these sections apply to notification of admissions.*
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					The HCS Medicaid Program Description, page 31, and Procedure MHSC-HCS-UM-364, Appropriate Professionals Making UM Decisions, describe staff who are licensed and trained to perform clinical reviews. Additionally, Procedure MHSC-HCS-UM-325, Authorization Process, indicates MDs, DOs, dentists, or licensed pharmacists as examples of qualified health professionals who can render denials and review cases which the HCS staff can not approve. Licensed pharmacists can render denials for pharmaceuticals only.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Sample UM approval files reflect timely determinations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Sample denial files reflect reasonable effort to obtain pertinent information.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Sample denial files reflect decisions were made by appropriate physician specialist.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Denial decisions are made according to the processes described in Procedure MHSC-HCS-UM-325, Authorization Process, and Policy MHSC-HCS-UM-383, Timeliness of UM Decision Making and Notification. Notice of Adverse Benefit Determination letters indicate the criteria used for decision-making and are signed by a representative from the organization. The letters do not clearly identify the physician issuing the denial determination as noted in Procedure MHSC-HCS-UM-325, Authorization Process (page 4). Onsite discussion revealed the physician who signs the letter is the same physician rendering the decision and is therefore identified. Additionally, it was discussed that Notice of Adverse Benefit Determination letters do not reference the date of service or the specific service being denied and that it would be helpful to providers or members to have a frame of reference when reviewing the denial information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Follow steps outlined in Procedure MHSC-HCS-UM-325, Authorization Process, on page 4 and revise Notice of Adverse Benefit Determination letters to include identification of the physician making the denial or remove this process step from Procedure MHSC-HCS-UM-325, Authorization Process. Revise denial letters to include the date of service and the specific service being denied so it can be easily referenced by the provider or member.
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy and Procedure MHSC MS-20, Member Appeals, define processes used in the Member Contact Center when an appeal request is received. The following policies and Procedures address processes followed by Member Inquiry Research and Resolution (MIRR) staff for handling and resolving appeals: •MHSC-MIRR-002, Standard Appeal Process •MHSC-MIRR-003, Expedited Appeal Process
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The terms “appeal” and “adverse benefit determination” are appropriately defined in all documents reviewed. Policy and Procedure MHSC-MIRR-002, Standard Appeal Process, Policy and Procedure MHSC-MIRR-003, Expedited Appeal Process, the Member Handbook, the Provider Manual, and the Notice of Adverse Benefit Determination letters indicate the member must provide consent for a provider or other representative

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to appeal on the member's behalf in writing. Issues noted related to written consent include: •The Molina website does not indicate that authorized representatives acting on the member's behalf and with the member's written consent may file appeals, or that a provider may serve as a member's authorized representative and act on the behalf of the member with the member's written consent. •During onsite discussion, Molina staff reported it considers the member's consent for treatment by the provider to serve as consent to appeal on the member's behalf. This is not reflected in the appeals policies and procedures (MHSC-MIRR-002 and MHSC-MIRR-003). *Recommendation: Update the website to include information that authorized representatives, including providers, may file appeals with the member's written consent. Update the appeals policies and procedures (MHSC-MIRR-002 and MHSC-MIRR-003) to include information that the member's consent for treatment serves as consent for the provider to appeal on the member's behalf.*
1.2 The procedure for filing an appeal;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					Policy MHSC-MIRR-002, Standard Appeal Process, defines individuals who make decisions on appeals. Molina occasionally refers appeals to AMR, an external review organization, when the plan has no internal reviewer of the same or similar specialty to render the appeal determination.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt. Regarding extensions of appeal resolution timeframes, pages 53 and 54 of the Member Handbook indicate that if an extension of the appeal resolution timeframe is requested, Molina must be able to explain to SCDHHS how the delay is in the member's interest. Molina must be able to explain the necessity of an extension only when the extension is requested by Molina, and not when requested by the member/authorized representative. Refer to the *SCDHHS Contract, Section 9.1.6.1.4.* *Recommendation: Update the Member Handbook to reflect that Molina must be able to explain the necessity of an appeal resolution timeframe extension for extensions requested by Molina only.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;		X				The *SCDHHS Contract, Section 9.1.6.3.1.3,* requires State Fair Hearings requests within 120 calendar days from the date of the notice of appeal resolution. The Member Handbook, page 54, states the 120-day timeframe to request a State Fair Hearing begins the date the member signs for the certified letter informing the member of the appeal decision, and the Provider Manual, page 119, states the timeframe to request a State Fair Hearing begins the date the determination notice is received. During onsite discussion, Molina staff reported the timeframe to request a State Fair Hearing begins on the date on the notice. *Quality Improvement Plan: Revise the Member Handbook and Provider Manual to reflect the correct timeframe for requesting a State Fair Hearing.*
1.7 Other requirements as specified in the contract.	X					Requirements for continuation of benefits are appropriately documented throughout all reviewed documents.
2. The MCO applies the appeal policies and procedures as formulated.	X					Appeal files reflected timely acknowledgements, decisions, and notifications. All were reviewed by the appropriate physicians, and appeal notices contained appropriate information.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The QI Program Description confirms the QI Department has responsibility for "ensuring compliance with Molina Healthcare and regulatory standards for timely response or resolution of complaints, grievances and appeals, in conjunction with UM and Member Services staff."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy MHSC-MIRR-002, Standard Appeal Process indicates all appeals are tracked and trended for analysis and reported to the QIC. Review of QIC minutes confirm detailed reports of appeals are provided and discussed.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					Policy MHSC-MIRR-002, Standard Appeal Process, states "MHSC shall protect the privacy and maintain the confidentiality of our members' Protected Health Information (PHI), in accordance with the state and federal law and contractual requirements including, but not limited to, the Health Insurance Portability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act provision of the American Recovery and Reinvestment Act of 2009 (ARRA)."
V. D Case Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The HCS Medicaid Program Description outlines the Care Management Program objectives. Several policies and procedures are in place to operationalize the program's processes, such as continuity of care and coordination, case management clinical guidelines and tools, and risk stratification. The Care Management Program is communicated in the Member Handbook and the Provider Manual.
2. The MCO has processes to identify members who may benefit from case management.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides care management activities based on the member's risk stratification.	X					Procedure MHSC-HCS-CM-051, Risk Stratification, describes the various levels of case management (CM) to which members may be assigned according to their individualized needs. Molina uses qualified case managers and staff to manage members in the appropriate risk level as outlined in Procedure MHSC-HCS-CM-066, Staff Structure and Roles. Additionally, care management activities are provided to members in Special Populations as described in Procedure MHSC-HCS-CM-001, Medical Service Delivery to Special Population.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Molina has care management programs and processes to provide coordination of care services to members. As required by the *SCDHHS Contract, Section 4.2.2.8*, the HCS Medicaid Program Description outlines care coordination, targeted case management, and enhanced services that are available and accessible to eligible members. The HCS Medicaid Program Description, page 55, does not include sensory impaired individuals in the list of services for targeted case management. Procedure MHSC-HCS-CM-081, Continuity of Care and Coordination, includes all conditions for which targeted case management services are available. Care Managers use the Clinical Care Advanced web-based health management documentation system to assess, coordinate, and manage care for members. This system has evidence-based and clinical decision-making tools that are consistent with NCQA and Utilization Review Accreditation Commission (URAC) Standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Procedure MHSC-HCS-CM-061, Initial Health Risk Assessment, references initial and comprehensive health risk assessments (HRA), and several references are made to "HCS staff." Section 3.9 of this procedure states, "Molina HCS staff will complete the Initial Health Risk Assessment." It is not clear if clinical or non-clinical staff are completing the initial health risk assessment (HRA). During onsite discussions, Molina explained that non-clinical staff complete the initial HRA, which is a 19-question telephonic screening tool, and if necessary based on the initial HRA results, a comprehensive HRA is completed by a clinical staff member. This explanation is consistent with Procedure MHSC-HCS-CM-066, Staff Structure and Roles. Molina also explained that an initial HRA is not completed if the member is receiving Transition of Care Services. This exception is not noted in Procedure MHSC-HCS-CM-061 Initial Health Risk Assessment. *Recommendation: Include the phrase "Sensory impaired individuals" in the 2017 HCS Medicaid Program Description when listing the 9 services for Targeted Case Management. In the Policy and the Procedure MHSC-HCS-CM-061 Initial Health Risk Assessment, indicate which HCS staff complete the initial and the comprehensive HRAs. Also, indicate the circumstances under which an HRA is not completed.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					
5.2 The MCO has a designated Transition Coordinator who meets contract requirements	X					The Care Management Department supervisor coordinates closely with the state Medicaid Agency and serves as the Transition Coordinator noted in the Continuity of Care Coordination policy.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The CM Program is incorporated into the HCS Program. As noted in the HCS Medicaid Program Description, page 68, "The written HCS Program is reviewed, evaluated and updated annually under the direction of the HCS Committee and QIC. A quantitative and qualitative analysis is completed to identify barriers and assess if annual goals were met. Corrective action plans will be developed for goals that are not met." The 2016 Case Management Effectiveness Evaluation, page 9, includes opportunities for improvement and planned interventions that are reported to a committee for review, recommendations, and approval. Surveys of member satisfaction with case management are conducted telephonically by Molina staff using standardized tools.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate care management activities are conducted as required and case managers followed policies to conduct the appropriate level of case management.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					Policy MHSC-HCS-UM-362, Monitoring to Ensure Appropriate Utilization, describes processes to verify Molina monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under- or over- utilization that may affect health care services, coordination of care, and appropriate use of services and resources.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					The 2016 QI Program Evaluation and Over- and Under-Utilization Excel files for Q1 to Q4 2017 indicate Molina analyzes data on the following topics regarding utilization: •Inpatient Utilization •ER Utilization •Admits •Readmissions Molina analyzed and monitored data and offered recommendations for the several services regarding utilization in the QIC meetings and in the QI Program Evaluation.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all subcontractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Molina executes written agreements with all entities performing delegated services. CCME received a sample credentialing delegation addendum in the desk materials. Molina delegates credentialing and recredentialing to the following entities: Bon Secours St. Francis (BSSF), Managed Health Resources (MHR), AU Medical Center (AU), Greenville Hospital System (GHS), Medical University of South Carolina (MUSC), Regional Health Plus (RHP), March Vision Care, Mary Black Health Network, and United Physicians.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				The Delegation Oversight Committee provides oversight of delegated provider groups to ensure the delegated entities are operating in compliance with Molina's policies and procedures and applicable regulatory and accreditation standards. The committee meets at least quarterly and the Chairperson is responsible for representing the committee at the QIC meetings. Molina has a detailed oversight process for delegated entities that includes pre-assessment audits for potential delegates, annual oversight, and ongoing monitoring of monthly and quarterly reports. When deficiencies are identified, the plan implements corrective action plans with follow-up audits, as appropriate. The processes are outlined in several policies and procedures.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME received proof of oversight for the delegated entities and found the following issues: •CCME found inconsistency in scoring between the entities related to the Social Security Death Master File (SSDMF). For some entities, (i.e., MUSC, MBHN, and United Physicians) the score in the "Policies" section of the tool for the "Sanctions Screening Procedure" indicated 100% with a note the SSDMF was not included. For other entities (i.e., AU Medical Center, GHS, BSSF) it was scored 0%, which indicated "not in compliance." Some entities had this issue as Corrective Action Items, some were Recommendations; MBHN was not included as a follow-up item even though a note indicated no record of checking the SSDMF. •For MUSC, the file review worksheets in the tool showed N/A for ownership disclosure form in the file, yet the overall score for the audit was 100%. During onsite discussion, Molina indicated the entity did have the ownership disclosure forms in a different file, they were just not in the credentialing/ recredentialing files. CCME questioned why they were scored N/A. It appears the entity met the requirement by obtaining the ownership disclosure forms. *Quality Improvement Plan: CCME recommends training for the delegation oversight reviewers to ensure consistency of how they review delegated entities.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V II. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					The Provider Manual informs that Molina monitors providers at least annually to ensure all EPSDT services, including immunizations, are provided timely and according to guidelines. Procedure MHSC QI 120.000, Assessing for Standards of Medical Record Documentation, confirms medical record documentation standards include the requirement to record immunization status in pediatric records (under 19 years of age). Quality Improvement (QI) medical record review specialists conduct annual medical record reviews to ensure provider compliance with administering required immunizations.
1.2 performing EPSDTs/Well Child Visits.	X					The Provider Manual includes guidelines for EPSDT/well-child visits and informs providers that they are required to deliver the identified services. The Provider Manual also states providers must demonstrate compliance with Molina's medical record documentation guidelines, including documentation of age-appropriate screenings provided in accordance with the periodicity schedule and all EPSDT related services. Provider compliance with performing ESPDT/well child visits is monitored annually through the medical record review process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	X					